

Spell Questionnaire

Today's Date: _____

Patient: _____

Onset (age/mo/yr): _____

Last spell was: _____

Frequency (now): _____ every: day / week / month / year

Freq Trend: increased no change decreased

Duration: _____ seconds / minutes / hours

During: awake / sleep / morning / night

Known causes? _____

Injuries? stitches / concussion / fractures / near drowning

Spell Description (in your own words):

Before Spell(s)

There is a warning? Yes No

If yes, what happens? _____

If yes: how long? _____

Other: _____

During Spell(s)

turns blue around mouth

breathing is abnormal: How? _____

falls bites tongue urinates soils pants

Other: _____

After Spell(s)

Normal

Sleepy / sleeps

Irritable / cries

Other: _____

What tests have been done (circle)?

EEG

When? _____ Where? _____

Head CT /MRI

When? _____ Where? _____

(other) _____

When? _____ Where? _____

What treatments have been used?

None

Can't remember the name(s)

Treatment Tried (☒)

ACTH shots (ACTHar gel®)

Felbamate (Felbatol®)

Gabapentin (Neurontin®)

Levetiracetam (Keppra®)

Phenobarbital

Valproic Acid (Depakote®/Depakene®)

Zonisamide (Zonegran®)

Vagus Nerve Stimulon

Problems?

Treatment Tried (☒)

Carbamazepine (Carbatrol®/Tegretol®)

Ethylsuximide (Zarontin®)

Lamotrigine (Lamictal®)

Oxcarbazepine (Trileptal®)

Phenytoin (Dilantin®)

Vigabatrin (Sabril®)

Ketogenic Diet

Epilepsy Surgery

Problems?

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