Austin Health

## Adult Epilepsy Questionnaire

U.R Number ……

Surname ……

Given Name(s) ……

Date of Birth ……

**AFFIX PATIENT LABEL HERE**

FAH028298

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To aid in assisting you I would appreciate if you could take time to fill in this registration form and bring it with you to the appointment or return via email or fax (details above).

**Personal Details**

Surname.....

First Name.....

Date of Birth ..... Sex .....

Address .....

.....

Home Telephone No..... Mobile .....

Occupation.....

**Family History**

Are your parents related? (For example, first cousins) ☐ YES ☐ NO

Parents' Age Mother..... Father.....

***Siblings***

| Name | Date of Birth |
|---|---|
| ..... | ..... |
| ..... | ..... |
| ..... | ..... |

Have there been any miscarriages/still births?.....

Is there family history of fits, slow development, any serious family illness or anyone in the family with problems like yourself? (Please bring details).....

.....

Is there anyone in the family who is left handed? ☐ YES ☐ NO If so, who? .....

**Your mother's pregnancy**

Was she well during pregnancy? (Flu, colds, operations, accidents).....

Did she smoke during the pregnancy? ..... Drink alcohol? .....

Was her tummy very large or small?.....

Did the child move normally inside her or stop moving for any period?.....

Did she take any medicine during the pregnancy? .....

Was there any bleeding or fluid loss before the delivery, if so when? .....

Did she have any ultrasounds, if so when and result(s)? .....

.....

Did she have any X rays during the pregnancy?.....

Adult Epilepsy Questionnaire

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**Birth**

Name and address of where you were born.....

Mother's name at time of delivery .....

Your name at time if different from your name now .....

Did your mother start labour naturally?.....

Were you born early, late or on time? (eg 3 wks early).....

How long was the labour?.....

Was any help necessary with forceps or was a caesarean performed? .....

What was your birth weight?.....

Did your condition at birth cause any concern? .....

Were you in good condition at birth?.....

Did you have to stay in the special care nursery for any reason? .....

Did you feed slowly or require tube feeding?.....

Were you very irritable or very sleepy?.....

Were there any attacks of any kind? .....

When did you go home and what was the weight?.....

**Development**

How old were you when you?

Smiled..... Sat unsupported.....

Crawled ..... Walked unaided .....

Said first word ..... Put 2 words together .....

Have you lost the ability to do any skills or tasks that you could formerly do? .....

**Immunisation**

Are you fully immunised? ☐ Yes ☐ No

Details.....

**Other Illnesses**

Details.....

**Fits/Seizures/Convulsions**

Age of first fit/seizure/convulsion.....

How often do they occur?.....

What do they look like? .....

What time of day do they occur?.....

When was the last one?.....

Any medicine given? .....

Any febrile convulsions? .....

Are you ☐ Left or ☐ Right handed

Name and address of family doctor.....

.....

Medicare No/Ref..... ..... Exp .....

Name of person completing form..... Relationship to patient.....

Date.....