Child Epilepsy Questionnaire

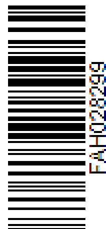
U.R Number ....

Surname ....

Given Name(s) ....

Date of Birth ....

AFFIX PATIENT LABEL HERE



Professor Ingrid Scheffer
MBBS PhD FRACP
Paediatric Neurologist & Epileptologist
Phone (03) 9035 7344 **Fax** (03) 9496 2291 Email pa-erc@unimelb.edu.au

Correspondence to:
Epilepsy Research Centre
Level 2, 245 Burgundy Street
Heidelberg VIC 3084

Dear Parent(s),
To aid us in assisting your child 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).

Child's Personal Details
Surname..
First Name..
Date of Birth .... Sex ....
Address ....
....
Home Telephone ....

Mother's Name.. Mobile ....
Occupation.. Work Phone No ....

Father's Name .... Mobile ....
Occupation.. Work Phone No ....

Family History
Are the parents related? (For example, first cousins) YES / NO
Parents' Age Mother.. Father..

Other Children
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 your child? (Please bring details) ....
....

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

Pregnancy
Were you well during pregnancy? (Flu, colds, operations, accidents)..............................
Did you smoke during the pregnancy?.............................. Drink alcohol? ....
Was your tummy very large or small?..
Did the child move normally inside you or stop moving for any period? ....
Did you take any medicine during the pregnancy?..
Was there any bleeding or fluid loss before the delivery, if so when? ....
Did you have any ultrasounds, if so when and result(s)?..
....
Did you have any X rays during the pregnancy? ....

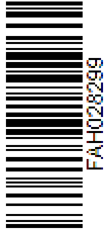
Child Epilepsy Questionnaire

M153.99

Child Epilepsy Questionnaire

U.R Number ……………………………………………..
Surname ………………………………………………
Given Name(s) ………………………………………..
Date of Birth ..……………………………………..……

AFFIX PATIENT LABEL HERE



Birth
Name and address of where baby was born ....
Your name at time of delivery ....
Baby's name at time if different from now ....
Did you start labour naturally?..
Was baby 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 the baby's birth weight?..
Did baby's condition at birth cause any concern?..
Was he/she in good condition at birth? ....
Did he/she have to stay in the special care nursery for any reason?..
Did baby feed slowly or require tube feeding? ....
Was he/she very irritable or very sleepy? ....
Were there any attacks of any kind?..
When did baby go home and what was the weight? ....

Development
How old was your baby when he/she?
Smiled .... Sat unsupported...
Crawled.. Walked unaided ....
Said first word.. Put 2 words together ....

Has your child lost the ability to do any skills or tasks that he/she could formerly do?..............................

Immunisation
Is your child 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?..

Is your child ☐ Left or ☐ Right handed

Name and address of family doctor ....
....

Name and address of paediatrician..
....

Medicare No/Ref .... Exp ....
Name of person completing form……………………………………………… Relationship to patient……………………….
Date……………………………..