Pediatric Epilepsy Program

Children's of Alabama®

Epilepsy Monitoring Unit Intake Form

Child's Name: _____ Is your child right or left handed? _____

Event History:

Event Type 1 Description (Give exact details about how it starts, what happens next, and how it ends):

_____

_____

How long does the event last? _____ How often does the event occur? _____

Does anything bring these events on? _____

Last time the patient had this event type: _____ Events started at what age? _____

What does the patient look like or do after the event? _____

Event Type 2 Description (Give exact details about how it starts, what happens next, and how it ends):

_____

_____

How long does the event last? _____ How often does the event occur? _____

Does anything bring these events on? _____

Last time the patient had this event type: _____ Events started at what age? _____

What does the patient look like or do after the event? _____

If there are more than 2 event types, please turn over to the back and continue describing the seizures.

Birth History:

Were there any problems during pregnancy or delivery?_____

_____

Birthweight _____ Natural Delivery or c-section Full term or premature

Did your child go home with you from the hospital? _____

Developmental History

Age at which patient start talking _____ Age at which patient started walking? _____

Past Medical History

Has the patient ever had convulsions with a fever? _____ At what age? _____

Has the patient ever been knocked unconscious or had any other major head injury? _____

Has the patient ever had an infection of the central nervous system? (ex: meningitis) _____

Please list any other medical problems your child has._____

_____

Has your child ever had neurosurgery? _____

_____

Has your child ever had a CT scan or MRI? (If so, when and why?) _____

_____ Was it normal? _____

Has your child ever had an EEG? (if so, when and where?) _____

_____ Was it normal? _____

Does your child have past behavioral/psychiatric problems? _____

_____

Family History

Seizures _____

Headaches_____

Developmental problems_____

Birthmarks_____

Social History

Who lives in the house with the patient _____

Does patient go to school? _____ What grade? _____ What kind of grades? _____

Do they require any special assistance? _____ What type of special assistance? _____

Please list all the medications that the patient is taking:

Medication:	Dosage:
_____	_____
_____	_____
_____	_____
_____	_____

Circle the medications/treatments that your child has tried for seizure control:

Dilantin (Phenytoin)	Lyrica (Pregabalin)	Tranxene (Clorazepate)	Gabatril (Tiagabine)	Neurontin (Gabapentin)	Diamox (Acetazolamide)
Vimpat (Lacosamide)	Felbatol (Felbamate)	Lamictal	Topamax (Topiramate)	Banzel (Rufinamide)	Zarontin (Ethosuximide)
Zonegran (Zonisamide)	Keppra (Levetiracetam)	Klonopin (Clonazepam)	Mysoline (Primidone)	Onfi (Clobazam)	Trileptal (Oxcarbazepine)
Tegretol (Carbamazepine)	Depakote (Divalproex Sodium)		Sabril (Vigabatrin)		Carbatrol (Carbamazepine)
Vagus Nerve Stimulator		Ketogenic Diet	Phenobarbital		ACTH

If you are interested in an epilepsy newsletter, please provide your name and email address below:

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Orig 2/14
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