Seizure Questionnaire

Name: _____ SSN: _____

Please answer the following questions concerning your BEST ESTIMATE **of your patient's impairments. Attach all relevant treatment notes, radiologist reports, and laboratory and test results.**

1. Does your patient have a seizure disorder? _____

2. Have your patient's impairments lasted or can they be expected to last at least twelve months?
□ Yes □ No

3. How long has your patient had seizures? _____

4. What medication(s) is your patient taking for seizures? _____

5. Does taking medication(s) affect the patient's seizure control?
_____
_____

6. Does patient comply with medication? _____

7. Is there any medication toxicity? _____

8. When do the seizures occur?

a) Pattern? _____

b) Duration of each attack? _____

c) Time of occurrence (Diurnal or Nocturnal): _____

d) Relationship to other precipitating factors?
_____
_____

9. Are the seizures stereotyped or are there multiple clinical seizure patterns?
_____
_____

10. To what degree is the patient limited in the ability to deal with work stress?
□No limitation □Slight □Moderate □Marked □Severe limitation

11. Are your patient's impairments likely to produce "good days" and "bad days"? □Yes □No

12. Is your patient a malingerer? □Yes □No

13. Please classify the type of seizures your patient has by circling below:

1. **<u>Generalized seizures:</u>**
   a) **Tonic Clonic**
   b) **Absence**
   c) **Tonic or Atonic**
   d) **Myoclonic**

OR

2. **<u>Partial seizures:</u>**
   a) **Simple partial (consciousness preserved)**
   b) **Complex (consciousness impaired)**

OR

3. **<u>Secondarily Generalized seizures:</u>**
   a) **Simple Partial evolving to generalized seizure**
   b) **Complex Partial evolving to generalized seizure**
   c) **Simple Partial evolving to complex partial, then to generalized seizure**
   d) **Complex Partial evolving to complex partial, then to generalized seizure**

Date: _____ **Signature: _____**

Printed/Typed Name: _____

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