AlfredHealth

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☐ Alfred ☐ Sandringham ☐ Caulfield

EPILEPSY HEALTH QUESTIONNAIRE

Family Name*		Given Name*	
Date of Birth*		Sex	☐ Female ☐ Male ☐ Other

*mandatory fields

Steps to completing this questionnaire,

1. Save questionnaire to your computer and answer questions
2. **email to** epilepsy@alfred.org.au
3. **or** post to: Epilepsy Program, Alfred Health, PO Box 315, PRAHRAN VIC 3181

- This questionnaire is to help gather information about your seizures or events, and identify other health considerations
- If you have questions – call **9076 2497** between 9:00am & 4:30pm Monday to Friday

Address					
Telephone		Email			
Medicare Number		Reference		Expiry	
☐ Public ☐ Private ☐ Pensioner ☐ TAC ☐ WorkCover ☐ DVA ☐ Other					
Do you need an interpreter to assist in discussing medical information			☐ Yes ☐ No		
If yes, language					
Cultural considerations					
Aboriginal or Torres Strait Islander	☐ Yes _____ ☐ No ☐ Not specified				
Do you have an advance care directive	☐ Yes ☐ No	*If yes, provide a copy*			
Do you have a Medical Treatment Decision Maker	☐ Yes ☐ No *If yes, provide a copy* If yes, name				
Alternative Contact Person name					
Relationship		Telephone			
GP Name		GP Telephone			
GP Address					
Pharmacy Name		Pharmacy Telephone			

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GENERAL QUESTIONS			
Which hand is your dominant hand?	☐ Left ☐ Right ☐ Both		
Do you have a driver's licence?	☐ Yes ☐ No	If yes, are you driving?	☐ Yes ☐ No
Are you currently employed?	☐ Yes ☐ No If yes, specify		
MEDICAL QUESTIONS			
ALLERGIES Do you have any allergies?	☐ Yes ☐ No	If yes, specify allergy and reaction	
Medical conditions *list*			
Mental Health conditions *list*			
Disability or support needs Eg, *speech, intellectual, visual, hearing, mental health / psychosocial, acute brain injury, physical, neurological*			
Do you have a behaviour support plan?	☐ Yes – provide copy		
Do you receive NDIS funding?	☐ Yes - NDIS number		
SOCIAL HISTORY			
Who do you live with?			
Do you currently smoke?	☐ Yes - How many per day		
Do you currently vape?	☐ Yes - How many times per day?		
If a previous smoker, when did you stop smoking?			
If a previous vaper, when did you stop vaping?			
Do you drink alcohol?	☐ Yes - How many standard alcohol drinks per day?		
Do you use recreational drugs?	☐ Yes - type, amount and frequency		
EPILEPSY HISTORY			
What age did your seizures start?			
Focal or generalised onset *(if known)*			
Have you ever had a convulsion?	☐ Yes		
Have you ever had STATUS epilepticus?	☐ Yes	Date	
Is there anything that brings on your seizures?			
Family History of Epilepsy Is there a family history of epilepsy? If yes, who is this and what kind of seizures do they have?			

Describe your seizures What it looks like	How often they happen	How long they last
• • •		

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Epilepsy Risk Factors

Where there any issues you are aware of when your mother was pregnant with you, or during birth? *describe*	
Development history: did you meet all the milestones or have any physical or health problems or disabilities?	
Have you had any damage to the brain or an infection *(eg, tumour, stroke, meningitis, viral encephalitis)*?	
Did you have febrile convulsions as a child?	☐ Yes
Have you had any significant head trauma?	☐ Yes

Antiepileptic Medications

CURRENT Antiepileptic Medication Name	**How much (dose)**	**How often each day (frequency)**	**When did you start this medication**	**Any adverse reactions?**
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No

PREVIOUS Antiepileptic Medication Name	**How much (dose)**	**How often each day (frequency)**	**When did you stop this medication**	**Reason for stopping medication**

List **all** other medication / tablets / puffers / eye drops / vitamins / herbal medicine that you currently take *(attach separate list if required)*. Bring all of your medication with you for your admission.

Medication Name	**How much (dose)**	**How often each day**

INVESTIGATIONS

Have you had an EEG	Date		Location	
Have you had a brain MRI or CT	Date		Location	

I have provided complete and accurate answers to this questionnaire to the best of my knowledge.

Name of person completing form		Date	

Person/s completing this questionnaire ☐ Patient ☐ Relative/ Carer ☐ GP ☐ Other clinician

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