Epilepsy History Form

To be completed by the Paediatric Neurologist and forwarded with initial referral at least 12 months prior to actual date of discharge from Paediatric Services.

1. Epilepsy aetiology: _____

2. Epilepsy syndrome: _____

3. Age of onset (first seizure and then epilepsy): _____

Age first febrile seizure _____ Age first afebrile seizure _____

4. Seizure types since epilepsy onset:

_____

_____

_____

_____

_____

_____

5. Current seizure control (frequency per month) according to seizure type:

_____

_____

_____

_____

_____

_____

6. Longest seizure free interval since onset of epilepsy: _____

7. Any recurring precipitating factors: Yes/No/Unknown

If yes, please specify.

_____

_____

8. Neurological examination and intellectual assessment:

a) Neurological exam: Normal/Abnormal

Relevant findings:_____

_____

_____

b) Intellectual evaluation: (tick appropriate)

__ Normal intelligence

__ Mild learning disability

__ Moderate or severe intellectual disability (full scale IQ <70)

- Intellectual evaluation was determined by: (tick appropriate)

__ Paediatrician in the clinic

__ School reports

__ Psychiatrist

__ Psychologist/Neuropsychologist

__ Other (explain) _____

9. Psychiatric comorbidities: (tick appropriate)

__ None

__ Depression

__ Anxiety

__ Psychosis/behavioural

__ Autism spectrum disorder

__ Other (explain) _____

_____

- Psychiatric evaluation completed by:

___ Patient self-assessment

___ Psychiatrist

___ Social worker

___ Other (explain) _____

___ Not done

10. Neuroimaging findings (including fMRI): brief summary, dates and results including private imaging (attach reports if not on PACS)

_____

_____

_____

_____

_____

11. EEG summary of significant findings over the years and date of most recent EEG (attach reports)

12. Video EEG: Not done__Done___ (Please attach all reports + brief summary)

13. SPECT: Not done___ Done___ (Please attach all test results if not on PACS)

14. PET: Not done___ Done___ (Please attach all test results if not on PACS)

15. Metabolic tests: Not done___ Done___ (Please attach all reports)

16. Genetic tests: None done___ Done___ Date_____ Type_____

Results (Please attach all genetic test results): _____

17. Epilepsy Surgery: Not done ___Done___

a. Date of surgery/Hospital: _____

b. Type of surgery: _____

c. Pathology: _____

18. Seizure control 1 year after surgery:

19. Neuromodulation: Not done_____ Done_____

a. VNS: date implanted (age) _____

b. VNS model/serial number _____

b. Date battery replaced (age) _____

c. Battery not replaced _____

d. Seizure control after VNS implantation _____

e. Others (VP shunt/pacemaker): _____

20. Ketogenic or other diet for epilepsy (specify):_____

• Never done_____

• Tried between the ages of _____ and _____

• Results: _____

_____

• Reasons for discontinuation: _____

• Plans to continue on the diet? ___Yes ___No

21. Antiepileptic drugs (AEDs) used previously, maximal dose and reason for discontinuation (including allergic/idiosyncratic reactions), include steroids and IVIG

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____
11. _____
12. _____
13. _____
14. _____
15. _____

22. Current AEDs, approximate date started, benefit, issues (including IPA/Hospital only prescriptions e.g. rufinamide, stiripentol, clobazam, CBD + indicate if obtaining via hospital)

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____

23. Current acute seizure management plan: ___Yes ___No

_____

_____

_____

_____

24. Episodes of status epilepticus or non-convulsive status? ___Yes ___No

Explain approximately how many times, triggers, previous treatment successes/failures.

_____

_____

_____

25. Other medications/supplements used regularly:

Stimulants: _____

Psychotropic drugs: _____

Melatonin, formulation/s and doses: _____

Calcium/vitamin D _____

Folic acid (dose) _____

Contraception (type) _____

Others: _____

26. Family history of epilepsy or other relevant conditions: _____

_____

27. Other significant medical conditions/comorbidities (include who is managing) or relevant other information:

1. _____
2. _____
3. _____
4. _____

Referrals sent to other specialties (tick as appropriate):

___Gastroenterology for PEG (including where to source equipment for PEG feeds)

___Botox (indicate limb, salivary or other): Neurology___ Rehab Med___

___Psychiatry (including for stimulant prescriptions)

___Rehabilitation (for wheelchair or other mobility aids used)

___Other services utilised or referred: _____

_____

_____

Completed by: _____ Date: _____