Patient EEG Questionnaire

Name: _____ DOB: _____ Age: _____ Date of Study: _____

Ordering Physician: _____

1) Reason for this Study: _____

_____

2) Had Seizures Before? _____ _____ Date of Last Seizure: _____ Description of seizures_____
Yes No

_____

_____

Family History of seizures: ____ ____ how are they related: _____
Yes No

3) Current Medications: _____

_____

4) Ever had brain surgery? ____ ____ If yes, Date of Surgery: _____ Which Side? _____
Yes No

Reason for surgery: _____

5) History of brain tumor? ____ _____ if yes, Date discovered: _____ Which Side? _____
Yes No

Type of tumor? _____

6) History of CNS infections? ____ ____ if yes, Date discovered: _____
Yes No

7) History of head trauma? ____ _____ Date of Trauma: _____ Loss of Consciousness? _____ _____
Yes No Yes No

8) Please list other health Issues._____

_____

_____

Below to be completed by Tech:

Tracking # _____

System # _____