

Northeast Regional Epilepsy Group

Patient EEG & AEEG Questionnaire

Name: _____	DOB _____	Age: _____
Study Date: _____	Referring Physician: _____	

1) Reason for this Study: _____

2) Had Seizures Before? Yes No If yes, Date of Last Seizure: _____

Description of seizures: _____

3) Current Medications: _____

4) Ever Had brain surgery? Yes No If yes, Date of Surgery: _____

If yes, which Side? (circle) Right left unknown both

Reason for surgery: _____

5) History of brain tumor? Yes No If yes, Date Discovered: _____

Type of tumor? _____ Which Side? (circle) Right left unknown both

6) History of CNS infections? Yes No If yes, Date Discovered: _____

7) History of head trauma? Yes No If yes, Date of Trauma: _____

Loss of consciousness? Yes No

Below to be completed by Tech:	
AEEG System No.:	<input type="text"/>
PC Card No.:	<input type="text"/>