Parent Interview Questionnaire for Seizure History

Child’s Name __________________________ Birthdate ________ Age ________ Grade ________
Teacher_______________________________ Information provided by __________________ Date ________

Please answer all questions. Use the back of this form for explanation or any additional information.

Who does your child see for regular health visits? ______________________________________ Phone __________
Who does your child see for seizure management? ______________________________________ Phone __________
When was your child diagnosed with seizure disorder? __________________________ at age ________
Has your child been diagnosed with any other medical conditions?  □ No  □ Yes (Please explain)

What symptoms does your child experience during a seizure ____________________________________________

Is your child aware of an aura (distortion of vision, hearing or smell) before a seizure __________________________

What words would your child use to describe the above symptoms __________________________________________

Does your child lose consciousness during a seizure?  □ No  □ Yes
How often does your child experience a seizure? _____ x a month _____ x a day  other __________
How long does your child’s seizure typically last? __________________________________________
When was your child’s last seizure (date/time/duration)? __________________________________________
Has your child experienced a seizure lasting longer than five minutes? □ No □ Yes (Please explain)

Has your child ever gone to the emergency room or been hospitalized for his/her seizures? □ No □ Yes (Please explain)

What events might trigger a seizure for your child? __________________________________________

What medications does your child take to manage his/her seizure disorder?
Name of medication __________________________ Amount __________ When taken __________________

Has your child been instructed on when and how to take these medications independently? □ No □ Yes
Are there any side effects from your child’s medications that his/her teacher needs to be aware of? □ No □ Yes (Please explain)

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Are there any side effects from your child’s medications that his/her teacher needs to be aware of? □ No □ Yes (Please explain)

Is your child participating in sports or school sponsored extra-curricular activities? □ No □ Yes (Please explain)

What are your child’s feelings about having a seizure disorder? __________________________________________

Is your child comfortable alerting others when experiencing symptoms of a possible seizure? □ No □ Yes

Does your child wear a “medic alert” necklace/ bracelet? □ No □ Yes
Describe your child’s understanding of their seizure disorder? □ None/Limited □ Basic □ Knowledgeable
Has your medical provider indicated in writing that your child needs special accommodations in school? □ No □ Yes (Please explain)

Sample Seizure History Questionnaire NYSSHSC SN Toolkit 6/2012