Patient drop off and additional services sheet

Date:_____

Name of Patient:_____

Seizure patient questionnaire

1. At what age did the seizures begin?_____

_____

2. What circumstances surrounded your pet first seizure?_____

_____

3. What factors seem to bring on the seizures? (visitors, new pets, construction, etc)

_____

4. What does your pet act before, during, and after the seizures?_____

_____

5. How long do the seizures last?_____

_____

6. Has your pet been treated for epilepsy before?_____

_____

7. What medicines were prescribed and in what dosages?

_____

8. Was the treatment effective? _____

_____

9. Check all that apply

	Salivation		Unconsciousness		Post seizure activity in which abnormal behavior or mental state was noted
	Urination		Pale gums		
	Defecation (bowel movement, stool)		Persistent tonic motion (paddling)		
	Rhythmic contractions of facial or body		Collapse onto side		

Note:_____

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