[Date]

[Patient Name]
[Patient Address]
[Patient Phone Number]

Dear [Patient Name],

We have scheduled your neurology consultation for [Date] at [Time] with [Doctor's Name]. To ensure we provide the most accurate evaluation, please complete the following information regarding your recent seizure activity and bring it to your appointment.

1. Event History

When did your first seizure occur? _____

How many seizures have you had in total? _____

When was your most recent seizure? _____

2. Seizure Description

Do you experience a warning (aura) before the event? (e.g., smell, taste, fear, nausea)
_____

What happens during the event? (e.g., staring, shaking, loss of consciousness, stiffening)
_____

How long do the events typically last? _____

How do you feel after the event? (e.g., sleepy, confused, headache, sore muscles)
_____

3. Triggers and Patterns

Are there known triggers? (e.g., lack of sleep, stress, flashing lights, alcohol, missed meals)
_____

Do the events happen at a specific time of day or during sleep? _____

4. Medical and Family History

Have you ever had a serious head injury or meningitis? _____

Did you have febrile seizures (seizures with fever) as a child? _____

Is there a family history of seizures or epilepsy? _____

5. Current Medications

Please list all current medications, dosages, and any previous anti-seizure medications you have tried: _____

If anyone has witnessed your seizures, please ask them to attend the appointment with you or provide a written description of what they saw.

Sincerely,

[Doctor/Clinic Name]
[Contact Information]