## Saitama Medical University Hospital
## Epilepsy Center – Outpatient Questionnaire (Adult)

This questionnaire is intended to help organize information in advance so that your consultation can proceed smoothly. To provide comprehensive care that considers not only seizures but also overall health and daily life, some questions may appear unrelated to seizures. Please answer as much as you can. Completing this form in advance is recommended but not mandatory. You may also arrive 60 minutes before your appointment to complete it at the clinic. After being scanned into the electronic medical record, this questionnaire will be securely shredded.

Revised: March 15, 2023

---

**Please complete the form before your scheduled appointment time on the day of your visit.**

Height: cm Weight: kg

Body temperature: °C Pulse: /min

Blood pressure: / mmHg

Date of visit:

Patient name:

Sex: Male / Female Age:

Name of person completing this form:

Relationship to patient:

Consent

Do you consent to sharing medical information (medications, health checkups) via the My Number Insurance Card?

□ Yes □ No

Have you had a health checkup within the past year?

□ No

□ Yes → Date (Year / Month):

Findings:

Did you bring a referral letter from another medical institution?

□ No

□ Yes → Institution name:

Date of visit:

Treatment details:

Reason for Visit (check all that apply)

□ Request for examination/tests

□ Medication adjustment

□ To know whether I have epilepsy

□ Consultation regarding current diagnosis or treatment

□ Regular outpatient follow-up

□ Request for hospitalization

□ Other:

Seizure History

Age at first seizure/symptom: Date (Year / Month / Day):

Hospitals previously visited for seizures/symptoms: Hospital / Department / Period

Details of Seizures

1) Type and frequency of seizures:

Seizure 1 (description):

Frequency: per year / month / week / day: times

Seizure 2 (description):

Frequency: per year / month / week / day: times

Seizure 3 (description):

Frequency: per year / month / week / day: times

2) Aura before seizures?

□ No

□ Yes → Details:

3) Date of most recent seizure:

Year / Month / Day

Treatment

1) Current anti-seizure medication:

□ Not taking

□ Taking → Medication name:

2) Medications that were effective in the past:

□ None

□ Yes → Medication name:

3) Medications that caused adverse effects:

Medication name / Symptoms:

4) Other medications or supplements:

□ None

□ Yes → Name:

5) Factors that worsen seizures:

□ Alcohol □ Sleep deprivation □ Fatigue □ Stress/mental state

□ Premenstrual □ During menstruation □ Postmenstrual

Other Medical Issues

1) Current illnesses under treatment or diagnosed:

□ None

□ Yes → Diagnosis:

2) Symptoms of concern (check all that apply):

□ Depressed mood

□ Insomnia

□ Elevated mood (high tension)

□ Auditory hypersensitivity or hallucinations

□ Problematic behavior affecting others

□ Feeling persecuted or watched

□ Memory decline

□ Increased irritability

□ Sleepiness

□ Other:

Past Medical History

1) Febrile seizures in childhood:

□ No

□ Yes → Age: (Hospitalized / Not hospitalized)

2) Major illnesses or injuries requiring treatment or surgery:

Age / Diagnosis:

Allergies

□ None

□ Yes → Allergen:

Lifestyle

1) Smoking:

□ Non-smoker

□ Smoker → cigarettes/day

2) Alcohol:

□ Do not drink □ Occasionally (social drinking)

□ Drink regularly → Type/amount: ml, days/week

3) Substance dependence:

□ No

□ Yes

Family History

Father (age): Alive / Deceased (Illness):

Mother (age): Alive / Deceased (Illness):

Siblings:

Relationship / Age / Alive or Deceased / Illness:

Spouse:

□ None

□ Yes → Age / Occupation / Illness:

Children:

Number: (Sex / Age)

Family history of epilepsy or seizures?

□ No

□ Yes → Who:

Family history of neurological, psychiatric, or psychosomatic disorders?

□ No

□ Yes → Who / Diagnosis:

Family history of sudden death?

□ No

□ Yes → Who / Cause:

---

Developmental and Life History

1) Problems during pregnancy:

□ None

□ Yes → Details:

2) Delivery method:

□ Vaginal

□ Cesarean section

3) Birth complications:

□ Nuchal cord

□ Neonatal asphyxia

□ Other:

4) Developmental delay in speech or motor function:

□ None

□ Yes → Details:

5) Education:

Elementary / Junior high / High school / Vocational school / University / Graduate school

Public / Private

Regular class / Special support class

Graduated / Enrolled / Dropped out

Academic performance: High / Average / Low

6) Employment:

Current job:

Previous jobs (age range):

7) Marital status:

□ Single

□ Married (age):

□ Divorced (age):

For Female Patients

1) Menstrual cycle:

□ Regular (cycle: days)

□ Irregular

□ Absent since: Year / Month or Age

2) Relationship between seizures and menstruation:

□ None

□ Yes

3) Age at menarche:

4) Possibility of pregnancy:

□ No

□ Yes

□ Currently pregnant → Gestational week:

5) Currently breastfeeding:

□ No

□ Yes

Daily Living

1) People living together:

2) Sleeping situation:

□ Sleeps alone

□ Someone nearby or in same room

3) Driver's license:

□ None

□ Has license → □ Currently driving □ Not driving

4) Dominant hand:

□ Right □ Left □ Both □ Previously corrected

5) Social support systems used:

□ Medical expense subsidy

□ Mental disability certificate (grade: )

□ Disability pension (grade: )

□ Intellectual disability certificate (degree: )

□ Physical disability certificate (grade: )

□ Designated intractable disease system (disease name: )

□ Public assistance

□ Other:

6) Activities of daily living:

□ Independent

□ Requires assistance →

□ Eating □ Mobility □ Sleep/wake

□ Medication management □ Money management

□ Grooming/bathing □ Interpersonal communication