Saitama Medical University Hospital
Epilepsy Center – Outpatient Questionnaire (Pediatric)

This questionnaire is provided to help organize information in advance so that your child's consultation can proceed smoothly.

To provide comprehensive care that considers not only seizures but also overall development and health, some questions may seem 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.

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

Patient Name:

Date of Birth (YYYY/MM/DD):

Age:

Sex: Male / Female

1. Do you consent to sharing medication information via the My Number Insurance Card?

□ Yes

□ No

Please provide information regarding medication(s):

Medication name:

Dosage / duration:

2. Do you have a referral letter from another medical institution? Yes / No
If Yes, provide the following information.

Institution name:

Date of visit / treatment details:

3. What concerns do you have about your child today?

4. When (age) and by whom (parents, grandparents, health check, etc.) were these concerns first noticed?

5. Have you and/or your child visited any medical institutions regarding these concerns before? Yes / No
If Yes, please describe when (age), where (institution), what tests (EEG, CT, MRI, etc.), and what treatments (medications), if known.

6. Please provide information about pregnancy and birth (refer to the Maternal and Child Health Handbook if available).

Gestational age at birth: weeks days

Delivery method: Vaginal / Cesarean section / Assisted / Other

Birth weight: g

Length: cm

Head circumference: cm

Chest circumference: cm

Was there neonatal asphyxia (did not cry immediately after birth)? Yes / No

Was phototherapy required for jaundice? Yes / No

Were there any abnormalities during pregnancy? Yes / No
If Yes, specify what happened and at which week of pregnancy.

Any medications taken during pregnancy? Yes / No
If Yes, specify the name(s) of the medication(s) administered and when they were given.

Was there any NICU admission after birth? Yes / No
If Yes, specify the diagnosis, the name of the hospital, the period of hospitalization, and the details of treatment (if available).

7. Any major illnesses other than those listed above? Yes / No
If Yes, please provide details

8. History of seizures

Febrile seizures: Yes / No
If Yes, specify the age at onset and the number of episodes.

Seizures without fever: Yes / No
If Yes, specify the age at onset and the number of episodes.

9. Developmental milestones (refer to the Maternal and Child Health Handbook):

Social smile (months)

Head control (months)

Rolling over (months)

Sitting (months)

Crawling (months)

Standing with support (months)

Standing alone (years months)

Independent walking (years months)

Stranger anxiety (months)

Babbling (years months)

Pointing (years months)

First words (years months)

Two-word phrases (years months)

10. Current daycare/school attendance: Please check the applicable item(s) and provide the required information.

Not attending

Daycare / Kindergarten

Elementary or Junior High School – Regular class (grade)

Elementary or Junior High School – Special support class (grade)

Special needs school (grade)

Other (please specify) :

11. Do any of your family members have epilepsy or other neurological or neuromuscular disorders? If yes, please provide details.

12. Does your child currently have or have they ever had any allergies?

No / Yes If yes, please provide details.

13. Is the patient currently pregnant or breastfeeding? (female only)

No/ Yes If Yes: gestational week? / breastfeeding? Yes / No

Thank you for your cooperation.