McLaren
CARO REGION

Neuro Diagnostic Testing
EEG History Form

Name_____ MR#_____ DOB_____ Sex_____

EEG#_____ DOS_____ Tech_____

Referring Physician_____ Primary Complaint_____

Medications_____

_____

Level of Consciousness: Alert Lethargic Oriented

Level of Cooperation: Cooperative Restless Combative Unable to Understand Instructions

Seizures: Last Sz_____ Frequency _____ Aura_____

Loss of consciousness: **Yes or No** If so, for how long?_____

Eyes: **Open or Closed** during seizure

Skin: **Diaphoretic or Dry** during seizure

Disposition: **Limp or Stiff** during seizure

Seizure happened while: sitting standing walking running

Did they bite their tongue: yes no

Loss of continence: yes no

Any drooling: yes no

Any gurgling/choking: yes no

Any history of CHI with Loss of consciousness: yes no

Craniotomy: yes no

How did patient feel prior to seizure: _____

Description of event by family/friend: _____

_____

What occurred after seizure: _____

_____