Empire Diagnostic Solutions, Inc.
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Patient AEEG Questionnaire

Name: ______________________________ DOB _____________ Age: ______

Study Date: _______________ Referring Physician: _____________________________

1) Reason for this Study: ____

2) Had Seizures Before? ____ Yes ____ No If yes, Date of Last Seizure: _________________

Description of seizures: ____

____

3) Current Medications: ____

4) Ever Had brain surgery? ____ Yes ____ No If yes, Date of Surgery: _______________

If yes, which Side? (circle) Right left unknown both

Reason for surgery: ____

____

5) History of brain tumor? ____ Yes ____ No If yes, Date Discovered: __________________

Type of tumor? _____________________ Which Side? (circle) Right left unknown both

6) History of CNS infections? ____ Yes ____ No If yes, Date Discovered: ___________________

7) History of head trauma? ____ Yes ____ No If yes, Date of Trauma:: ___________________

Loss of consciousness? ____ Yes ____ No

Below to be completed by Tech:

AEEG System No.:

PC Card No.: