

VSA Seizure Questionnaire

Pet's name: _____

Your name: _____

Date of your appointment with VSA: _____

Thank you for taking the time to fill out this questionnaire. Please be as complete as possible with your answers. If you do not know the answer, or are unsure please write "do not know" in the space provided. If your pet has had multiple seizures please answer generally for the "typical" seizure.

General Care Questions

Who is your pet's primary care taker? (for example You, Your Spouse, Your Child, Etc)

How often is your pet left alone (i.e. while you are at work, school, on errands etc)?

Is your pet kenneled or allowed to roam free when alone?

Does your pet spend the majority of his/her time inside or outside?

Is there any possibility that your pet was exposed to any toxins (pesticides, lead paint, garbage, prescription medication etc?)

About Your Pet's Seizures

When was your pet's first seizure?

When was your pet's most recent seizure?

Were you present for the entire seizure? (If multiple seizures, please answer for the most recent seizure)

If your pet has had more than one seizure, how often does your pet seize? Please provide number of seizures per day and number of seizure days per week or month.

Can you think of any particular event or behavior that indicates a seizure is about to happen?

Do the seizures happen at a particular time of the day?

Is your pet often sleeping when the seizure occurs?

Describe the seizure.

Did your pet lose or have altered consciousness during the event?

Did you try to get your pet's attention (i.e. call his/her name, touch his/her side) during the seizure?

Did your pet:

Fall on one side? Yes No
If so, what side? Always the same side?

Paddle his/her legs? Yes No
If so, please list which limbs are involved.

Walk/Spin in Circles? Yes No
If so to what side (in what direction)?

Vocalize/howl? Yes No
Chewing motions? Yes No
Defecate? Yes No
Drool, regurgitate or vomit? Yes No
Walk/pace? Yes No
Urinate? Yes No
Turn blue/stop breathing temporarily? Yes No
Demonstrate destructive Behavior (biting at self, people or inanimate objects)? Yes No
Have abnormal rhythmic head movements (nodding or tremoring)? Yes No
Has your pet ever injured his/herself during or after a seizure? Yes No
Does your pet ever act aggressive towards you or your other pets before or after a seizure? Yes No
If you have other pets, how do they react before/during and after your pet's seizure? Yes No

What does you pet do after the seizures?

Walk/Spin in Circles? Yes No
If so to what side (in what direction)?

Hide or go to a certain room/place (i.e. bathroom, kennel)? Yes No
Eat/seem hungry? Yes No
Sleep? Yes No
Drink/seem thirsty? Yes No
Seek attention? Yes No

If behavior is abnormal after the seizure, how long does the abnormality last?

Other (please explain)?

Previous Diagnostics

Have you seen a veterinarian for this problem? Yes No

If you answered yes to the above, please list the doctor's name and hospital and if possible please contact this veterinarian and have them fax records to VSA before your appointment.

Veterinarian and/or hospital Name: _____

Has your pet had general bloodwork performed (Complete blood count and general chemistry screen)?

Yes No Unsure

Has your pet had liver function testing (ammonia levels or bile acids testing)?

Yes No Unsure

Has your pet had x-rays performed in the last six months? *If yes, please bring all x-rays to your appointment.*

Yes No Unsure

If your pet is a cat, has he/she been tested in the last year for FeLV and FIV?

Yes No Unsure

Has your pet had an MRI?

Yes No Unsure

If yes to the above, please list the body part and facility where this study was performed. Please bring a copy of the scan with you on CD if possible.

Please list any other diagnostics that your pet has had in the last six months or at the beginning of the seizure course (for example: infectious disease blood testing)

Medications

Has your pet been prescribed medication for this problem?

Yes No Unsure

If so please list the name, dose of the medications and frequency it is given (for example: Phenobarbital 60mg by mouth twice a day)

Has your pet had anticonvulsant blood levels measured?

Yes No Unsure

If yes to the above, please list or have faxed at a minimum the last two sets of test results.

If your pet has had a recent dose change of anticonvulsant medication please list the previous dose and the date the medications were last changed.

If your pet has been on multiple medications for seizures, is there one that you feel has worked the best?

Is there a medication that you do not want to try or use again?

Please list the side effects your pet has experienced from any medications? Side effects include (check all that apply):

- | | | | |
|---|--------------------------|---------------------|--------------------------|
| Difficulty getting around or "drunk" walking | <input type="checkbox"/> | Increased hunger | <input type="checkbox"/> |
| Decreased mentation or "zombie-like" behavior | <input type="checkbox"/> | Increased thirst | <input type="checkbox"/> |
| Increased liver enzymes | <input type="checkbox"/> | Increased urination | <input type="checkbox"/> |
| Red or white blood cell abnormalities | <input type="checkbox"/> | Skin problems | <input type="checkbox"/> |

Other: _____

Are these side effects tolerable at their current level? Yes No

Other History

Has your pet had surgery in relation to this seizure problem (liver shunt surgery, brain surgery)?

Yes No Unsure

If yes to the above, please list the doctor's name and hospital. Please contact this veterinarian and have them fax records to VSA before your appointment.

Date Veterinarian

Has your pet been diagnosed with or suspected to have arthritis? If so in which limb/joint?

Yes No Unsure

Has your pet ever been diagnosed with an ear problem?

Yes No Unsure

Has your pet ever shown signs of neck pain?

Yes No Unsure

Does your pet ever have trouble getting around (on slick surfaces? Up/down stairs?)

Yes No Unsure

Has your pet had any change in behavior recently?

Loss of house training? Yes No

Failure to recognize familiar people or places? Yes No

Failure to answer to name when called? Yes No

Going to the wrong side of doors? Yes No

Is it more difficult to wake your pet up? Yes No

Pacing? Yes No

Change in sleep patterns? Yes No

Slowing down? Yes No

Has your pet had any loss of vision recently (i.e. is he/she bumping in to objects)? Yes No

Have you noticed any other abnormalities with your pet? (please describe)

Is your pet vaccinated? Yes No

If yes to the above, when was the last set of vaccines? (For dogs, please list specifically the distemper and rabies vaccines. For cats, please list specifically the rabies vaccine)

Questions That Will Help Guide Us on How to Proceed

While our goal is to have your pet as seizure free as possible, 100% seizure control is not often possible. What is the maximum amount of seizures (i.e. number per month/year) that you feel you can tolerate?

Do you feel your pet's seizures are significantly affecting his/her quality of life?

Do you feel your pet's seizures are significantly affecting your quality of life?

What is your purpose in visiting with Neurology today? (please check all that apply)

Diagnose any underlying diseases causing seizures

Second opinion

Discuss medication, management

Other (please briefly describe) _____