

Registration form for patients with refractory epilepsy

Patient number:

* National Code:

Patient first name

Patient surname City:

Age:

Weight :

Service date :

Phone number(s):

Date of the first seizure:

Date of the last seizure:

Frequency of the seizure:

Seizure type :

Prenatal and perinatal history:

Familial History:

Neurological development:

Neurological examinations:

EEG findings:

Neuroimaging Findings:

Other investigations: (Genetics, ...)

Etiologic diagnosis:

Medicinal History :

- | | | |
|-----------------------|----------|--------------------------|
| 1. Type of medication | duration | cause of discontinuation |
| 2. Type of medication | duration | cause of discontinuation |
| 3. Type of medication | duration | cause of discontinuation |
| 4. Other medications: | | |

Current drugs and daily dosage:

Non-pharmacological treatments:(Surgery ‘ diet,...)

Complementary Medicine: (Herbal Medicine, Acupuncture, Energy Therapy, Prayer Writing, Yoga, Homeopathy...)

Treatment plan :(KD ‘VNS ‘collosotomy ‘Lesionectomy...)