CLINIC RESOURCE

# Feline Seizure History Collection Form

Video of the event available: Yes ☐ No ☐

Events prior to signs (e.g., stressful events, changes in household, application of medications, ate something unusual):

_____

Time of day event(s) occur: _____

Description of preictal period:

_____

Description of ictal period:

_____

Description of postictal period:

_____

Autonomic signs present: Yes ☐ No ☐ First-time seizure: Yes ☐ No ☐ Cluster seizure: Yes ☐ No ☐

If not first-time seizure:

How many seizures previously and date of first occurrence? _____

What is the frequency of seizures? _____

Any medications: Yes ☐ No ☐

If yes, which medications (mg, frequency of administration)?

_____

If yes, response to medications? _____

If yes, are there any side effects? _____

Any recent blood work or serum monitoring levels (phenobarbital)? _____