Epilepsy monthly follow up form / intake form
(to be kept in patient file at clinic)

1. Client Information	Date		Date of last medical visit	
Name		File No./Reg. No.		
Gender		DOB/Age		
Missed previous appointment(s)	Yes ☐ No ☐	If yes, how many and why?		
Currently came for:	a. Routine appointment ☐ b. Complication ☐ c. Other co-morbidity ☐			

2. Seizure related information	
Number of seizures since the last appointment	
Description of seizures	
Increase or decrease of seizures?	

3. Treatment related information			
Current antiepileptic treatment	Name		
	Dosage		
	Daily intake		
Adherence to treatment	Yes ☐ No ☐ (Reason:_____)	If No, how many days missed?	
Any adverse effects of medication?	Yes ☐ No ☐	If yes, specify _____ _____	
Any other treatment in addition to the antiepileptic drugs?	Yes ☐ No ☐	If yes, specify _____ _____	

4. Quality of life	
Ability to perform at school (*applicable to individuals of school-going age*)	a. Normal ☐ b. Moderately affected ☐ c. Unable ☐ If abnormal, describe_____
Ability to work at home or in the farm	a. Normal ☐ b. Moderately affected ☐ c. Unable ☐ If abnormal, describe_____
How do you compare the quality of life of the client against his/her status during the last appointment?	a. Much better ☐ d. Worse ☐ b. Better ☐ e. Much worse ☐ c. Same ☐ Remarks: _____ _____
Other relevant findings	

5. Any other complaint	
Any other symptom raised by patient or caretaker?	

6. Physical examination				
Vital Signs	Blood pressure		Height(cm)	
	Pulse rate		MUAC (cm)	
	Respiratory rate		Head circumference (cm)	
	Weight (kg)			
New traumatic lesions or burns?	Yes ☐ No ☐	If yes describe, _____		

Other relevant findings			
7. Nutritional Assessment	a. SAM ☐ b. MAM ☐ c. Normal ☐		
8. Conclusion and management			
Patient evolution	a. Improvement ☐ b. Degradation ☐ c. Same ☐	d. Other diagnosis, specify ☐ e. Complications diagnosed ☐	
Treatment	a. Same treatment ☐ b. Modified ☐ If modified, precise drug/dosage: _____	a. Medication given for 30 days ☐ b. Medication given for 60 days ☐ c. Medication given for >60 days, specify: _____days	
Loss to follow up/ defaulter client?	Yes ☐ No ☐	If Yes, mention reason_____ _____ and measures taken for the future_____ _____	
9. Community-level Follow-up	Is the client followed-up by a CHW/HHP/BHW/ CBR Worker? Yes ☐ No ☐ If Yes, Name:_____ Organization:_____ If No, refer to a CHW / CBR Worker and specify: - Name: _____ - Organization:_____		
10. Next appointment	Date		Day
11. Name and signature of health personnel _____ Name _____ Signature			