FAA Airman Seizure Questionnaire

(Updated 6/29/16)

The following questions should be **answered by the AIRMAN** who should read through the entire questionnaire and complete all sections as appropriate. If the seizures occurred when the airman was a child, a parent or guardian familiar with the episodes should complete this form.

Section 1 - Big Seizures

Have you ever had a grand mal seizure or a big seizure where you lost consciousness or your whole body shook and stiffened?			Yes **Go to A**	No **Go to Section 2** (next page)
A. How many have you had? *Enter a number*				
B. When was the first one? *Enter approximate date, how long ago, or your age at the time*				
C. When was the last one/most recent? *Enter the approximate date*				
D. Do you ever have a warning before your big seizure(s)?			Yes	No **Go to E** / Don't know
	D1. Did you ever have this warning and not have a seizure?		Yes	No / Don't know
	D2. When was the last warning? *Enter actual date OR how long ago (in months)*		Date: Or months ago:	
	D3. Did this warning consist of any of the following?	Unusual feeling in stomach or chest?	Yes	No / Don't know
		Unusual smells or tastes?	Yes	No / Don't know
		Hearing unusual sounds or hearing difficulty?	Yes	No / Don't know
		See anything unusual or have any change in your vision?	Yes	No / Don't know
		Behave in unusual ways such as smacking your lips, touching your clothes, or doing any other unusual things without intending to?	Yes	No / Don't know
		Have difficulty speaking or understand speech?	Yes	No / Don't know
E. Of the grand mal or big seizures that you had while awake, did they usually occur shortly after waking up? (Either in the morning or after a nap.)			Yes	No **Go to F** / Don't know
	E1. How many minutes after waking up would you say the grand mal or big seizure(s) usually occurred? *Check one*		[ ] 15 min or less [ ] 16-30 min [ ] 31-45 min [ ] 46-60 min [ ] More than 60 min	
F. Before the seizure started did you have jerking, shaking, or uncontrolled body movements or did your whole body jump suddenly, as if someone had startled you from behind?			Yes	No **Go to Section 2** (next page) / Don't know
	F1. Which side was affected? *Check one*		[ ] Left side only [ ] Right side only [ ] Both sides [ ] One side; unsure of which [ ] Don't know	

Airman Name _____ **MID#, PI#, or App ID#**_____

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Section 2 - Small Seizures

Have you ever had any small spells (other than grand mal or big seizures)?	Yes **Go to A**	No **Go to Section 3** (next page)	
A. When was the last time you had one of these spells? *Write in the approximate date OR age at which it occurred.*	Date:	Or age:	
B. How long would you say the spell lasted? *Check one*	[ ] 15 seconds or less [ ] 16-30 seconds [ ] 31 -59 seconds	[ ] 1-2 min [ ] More than 2 minutes	
C. During this most recent spell, which of the following best describes your awareness of the surroundings? *Check one*	[ ] Fully aware [ ] Somewhat aware, but less aware than usual	[ ] Fully unaware	
D. During this spell, were you able to FUNCTION as you normally do?	Yes	No	Don't know
E. During this spell, were you able to COMMUNICATE as you normally do?	Yes	No	Don't know
F. After the spell was over, did you remember what happened during the spell or did you learn about it from someone else?	[ ] Yes, I remembered	[ ] No, someone else had to tell me	
G. During this spell, did any parts of your body move uncontrollably?	Yes	No **Go to H**	Don't know
G1. Which parts of the body were involved?	[ ] Arm [ ] Face [ ] Leg	[ ] Other [ ] Don't know	
G2. Was this only on one side?	Yes	No	Don't know
H. During this spell, did any parts of your body JERK suddenly and unexpectedly?	Yes	No **Go to I**	Don't know
H1. Which parts of the body were involved?	[ ] Arm [ ] Leg [ ] Face	[ ] Other [ ] Total body [ ] Don't know	
H2. Was this on only ONE SIDE?	Yes	No	Don't know
H3. Which side?	[ ] Left [ ] Right [ ] One side; unsure which	[ ] Don't know	
H4. Have you ever had a similar spell with jerking on the opposite side?	Yes	No	Don't know
H5. Would you say the jerking felt like an electric shock going through your body?	Yes	No	Don't know
H6. Has this type of spell usually occurred shortly after waking up (either in the morning or after a nap)?	Yes	No	Don't know
H7. Does this type of spell occur only when you are going to sleep?	Yes	No	Don't know
H8. Did this type of spell ever occur as a result of lights shining in your eyes (for example strobe lights, video games, reflections, or sun glare?)	Yes	No	Don't know
I. During this spell, did you behave in unusual ways such as smacking your lips, touching your clothes, or doing any other unusual things without intending to?	Yes	No	Don't know
J. Did your eyelids flutter during this spell?	Yes	No	Don't know
K. Do you tend to be clumsy in the morning such as dropping things or spilling coffee?	Yes	No	Don't know
L. During your spells, did you ever have any other symptoms?	Yes **(explain in Section 5)**	No	Don't know

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(Printed)

Section 3 – Other

Do you ever have unexplained episodes of:

A. Unusual feelings in your stomach or chest?	Yes	No	Don't know
B. Unusual smells or tastes?	Yes	No	Don't know
C. Hearing unusual sounds or hearing difficulty?	Yes	No	Don't know
D. Seeing anything unusual or have any changes in your vision?	Yes	No	Don't know
E. Behaving in unusual ways such as smacking your lips, touching your clothes, or doing any other unusual things without intending to?	Yes	No	Don't know
F. Having periods of lost time due to "spacing out" or daydreaming?	Yes	No	Don't know
G. Awaking in the morning with a bitten tongue or a bloody pillow?	Yes	No	Don't know
H. Awaking in the morning with unexplained bed wetting?	Yes	No	Don't know
I. Other (or comments)	Yes **(explain in Section 5)**	No	Don't know

Section 4 - Medication History

A. I am currently taking medication to prevent or control my seizures.	Yes	No **Go to B**	Don't know
A1. Current medication information: *If you do not know the date or calendar year, enter your age when medication was started.*	Name of med:		
	Dosage:		
	Date started:		Or age:
B. I took medication in the past.	Yes	No **Go to Section 5**	Don't know
B1. Previous medication information: *If you do not know the date or calendar year, enter your age when medication was stopped.*	Name of med:		
	Dosage:		
	Date ended:		Or age:

Section 5 - Comments

Please enter additional explanation or comments for ANY part of this questionnaire:

If anyone other than the airman completed this form, list name and relationship to the airman:

Signature _____ **Date completed** _____

Airman Name _____ **MID#, PI#, or App ID#**_____

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