ARUP LABORATORIES

A nonprofit enterprise of the University of Utah and its Department of Pathology

500 Chipeta Way
Salt Lake City, UT 84108-1221
phone: 801-583-2787 | toll free: 800-242-2787
fax: 801-584-5249 | aruplab.com

THIS IS NOT A TEST REQUEST FORM. Please complete and submit with the test request form or electronic packing list.

EPILEPSY PATIENT HISTORY FORM

Patient Name: _____ **Date of Birth:** _____

Sex Assigned at Birth: ☐Female ☐Male ☐Intersex **Gender Identity (optional):** ☐Female ☐Male ☐_____

Ordering Provider: _____ **Provider's Phone:** _____

Practice Specialty: _____ **Provider's Fax:** _____

Genetic Counselor: _____ **Counselor's Phone:** _____

Patient's Ethnicity/Ancestry (check all that apply)

☐ African American/Black ☐ Asian ☐ Hispanic ☐ White ☐ Other: _____

Suspected clinical diagnosis: _____

Presence of seizures? ..... ☐ No ☐ Yes (check all that apply) ☐ Unknown

☐ Febrile seizures
☐ Epileptic (infantile) spasms
☐ Generalized onset nonmotor (absence)
☐ Other _____
☐ Focal: location_____
☐ Generalized onset motor
☐ Nocturnal seizures

Age at seizure onset _____

Frequency of seizures……..☐ daily ☐ persistent (< every 6 months) ☐ rare (> every 6 months) ☐ undefined

Refractory epilepsy……..☐ yes ☐ no

Does the patient have other clinical findings?..... ☐ No ☐ Yes (check all that apply) ☐ Unknown

Developmental/Behavioral	Physical Features	Motor/Tone
☐ developmental delay	☐ microcephaly	☐ hypotonia
☐ intellectual disability	☐ macrocephaly	☐ hypertonia
☐ encephalopathy	☐ overgrowth	☐ ataxia
☐ autism/autistic features	☐ dysmorphic features	☐ dystonia
☐ limited or absent speech	☐ hypopigmented macules	☐ spasticity
☐ developmental regression	☐ hyperpigmented macules	☐ tremor

Other Clinical Features: _____

EEG/VEEG: ☐ Normal ☐ Abnormal _____ ☐ Not performed

Brain MRI: ☐ Normal ☐ Abnormal _____ ☐ Not performed

Genomic Microarray: ☐ Normal ☐ Abnormal _____ _____ ☐ Not performed

Has the patient undergone previous DNA testing for epilepsy? .....☐ No ☐ Yes ☐ Unknown

If yes, describe the test(s) and results: _____

Is there any relevant family history of epilepsy?.....☐ No ☐ Yes ☐ Unknown

If yes, attach a pedigree or specify the relative's relationship to the patient. List their symptoms and age of onset:

Has DNA testing been performed for the family member(s)? .....☐ No ☐ Yes ☐ Unknown

If yes, attach a copy of the relative's DNA laboratory result (REQUIRED for familial variant testing).

For questions, contact an ARUP genetic counselor at 800-242-2787 ext. 2141.