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Before and During EEG Recording

Hours of sleep night before recording:
Hours since last meal:
Clean hair/no products/other:
Prepared for hair having leftover gel upon departure:
PRN medication (prescribed or over-the-counter or other within 24 hrs of recording):
Caffeine/nicotine/alcohol/THC within 24 hrs of recording:

LAST NAME:
FIRST NAME:
DOB:
AGE:
HANDEDNESS:
SEX AT BIRTH:
CURRENT MEDS:
PAST MEDS AND SIDE EFFECTS:
SIGNIFICANT IMPACTS TO HEAD INCLUDING DATES AND LOSS OF CONSCIOUSNESS:

SLEEP ISSUES WHETHER ONSET, MAINTENANCE OR BOTH:
CONVULSIONS/SEIZURE HISTORY (SELF OR FAMILY):
CURRENT SUBSTANCE ABUSE:
MEMORY DIFFICULTY:
ANXIETY/DEPRESSION:
EATING DISORDER:
HISTORY OF MENINGITIS/ENCEPHALITIS/CNS INFECTION:
DELUSIONS/HALLUCINATIONS/THOUGHT DISORDER:
PREVIOUS EEG:
HYPERACTIVITY/ATTENTION OR IMPULSE CONTROL:
HEADACHE HISTORY:
BLOOD PRESSURE ISSUES:
AUTOIMMUNE ILLNESS HISTORY:
FAMILY HISTORY OF MENTAL ILLNESS:
THYROID ISSUES/SELF OR FAMILY:
MISCARRIAGE/FAMILY OHISTORY:
FAMILY HISTORY OF STROKE OR HEART ATTACK IN 50'S OR 60'S:

DIAGNOSES:
WHAT QUESTIONS WOULD YOU LIKE ANSWERED:

FOR TECHNICIAN TO FILL OUT

Blood pressure/pulse/respirations/pulse oxygenation_______________________________________

Impedances/cap/metal____

Circumference/nasion to inion/tragus to tragus ____

Amplifier_______________________________

Technician______________________________

Time of test_____________________________

Observations

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