S Subjective

1 PATIENT IDENTIFICATION

Name:	Michael Anderson	**DOB / Age:**	03/14/1994 / 32 years
Sex:	Male	**MRN:**	78451239
Date of Visit:	04/01/2026	**Referring Provider:**	Dr. Laura Chen, PCP
Neurologist / Epileptologist:	Dr. Daniel R. Weiss, MD (Epileptology)	**Accompanied by:**	Wife (primary witness to seizure events)

2 CHIEF COMPLAINT

Primary concern: Recurrent episodes of loss of awareness with generalised shaking

Duration of symptoms: Approximately 8 months

3 HISTORY OF PRESENT ILLNESS

ONSET & TIMELINE

Date of first seizure:	August 12, 2025	**Course since onset:**	Gradually worsening in frequency and severity
Last seizure date:	March 28, 2026	**Seizure frequency:**	Initially 1/2–3 months; now 2–3/month

AURA / WARNING SYMPTOMS

Sensory: Occasional metallic taste preceding events. Autonomic: Rising epigastric sensation. Psychic: Déjà vu reported in ~50% of episodes.

ICTAL FEATURES

Loss of consciousness. Tonic stiffening followed by bilateral clonic jerking. Occasional rightward head deviation. Tongue biting (lateral). Drooling and cyanosis observed. Seizure duration approximately 1–2 minutes. Episodes begin abruptly, often in early morning or during fatigue.

POSTICTAL SYMPTOMS

Marked confusion and disorientation. Severe fatigue. Diffuse headache. Difficulty with word finding. Duration of recovery: 20–45 minutes.

SEIZURE TRIGGERS

Sleep deprivation (most consistent trigger). High work-related stress. Occasional alcohol intake prior to events.

INJURY DURING SEIZURES

Fall with minor scalp laceration (January 2026). Tongue biting. Urinary incontinence during 2 episodes.

FUNCTIONAL IMPACT

Driving privileges suspended. Reduced work productivity (software engineer working remotely). Avoidance of independent activities (e.g., swimming). Increased dependence on spouse for supervision.

4 SEIZURE CLASSIFICATION

Seizure type(s): Focal impaired awareness seizures with secondary generalisation

Classification (ILAE): Focal to bilateral tonic-clonic; consistent with temporal lobe onset

5 SEIZURE CONTROL STATUS

Last seizure date: March 28, 2026

Current seizure frequency: 2–3 per month

Change since last visit: Worsened

6 HISTORY OF STATUS EPILEPTICUS

History of prolonged seizure (>5 min): No documented episodes >5 minutes

Hospitalisation / ICU admission: No ICU admissions. One ER visit for prolonged postictal confusion (January 2026).

7 PRIOR NEUROLOGICAL EVALUATION

2 ED visits for seizure-related injuries. No hospitalisations. Evaluated by general neurologist in September 2025.

8 PAST MEDICAL HISTORY

No prior epilepsy diagnosis before 2025. No history of febrile seizures. Mild traumatic brain injury (sports-related concussion at age 19). Mild hypertension (well-controlled). Generalised anxiety disorder.

9 PAST SURGICAL HISTORY

Appendectomy (2012). No neurosurgical history.

10 MEDICATIONS

CURRENT ANTISEIZURE MEDICATIONS

Levetiracetam 1000mg BID. Adherence: Reports missing ~1–2 doses per week.

RESCUE MEDICATIONS

Intranasal midazolam 5mg PRN for seizures >3 minutes.

OTHER MEDICATIONS

Sertraline 50mg daily · Lisinopril 10mg daily. Side effects: Irritability and mood changes attributed to levetiracetam; mild fatigue.

11 ALLERGIES

Medication allergies:	Penicillin – rash
Reaction type:	Rash (non-anaphylactic)
Latex / contrast allergies:	None reported

12 SOCIAL HISTORY

Occupation:	Software engineer (remote)	**Alcohol use:**	Social, ~2–3 drinks/week
Driving status:	Not driving — suspended due to seizures	**Recreational drug use:**	Denies
Living situation:	Lives with spouse in apartment	**Sleep habits:**	Averaging 5–6 hrs/night (suboptimal)
Smoking status:	Never smoker	**Stress level:**	High due to work deadlines
Seizure safety precautions:	Partial compliance		

13 FAMILY HISTORY

No known epilepsy in family. Father: history of migraine. No genetic neurological disorders.

14 REVIEW OF SYSTEMS

NEUROLOGICAL

Recurrent seizures. Intermittent headaches postictally. No persistent weakness or numbness.

PSYCHIATRIC / COGNITIVE

Anxiety symptoms. Mild memory difficulty post-seizure.

CARDIOVASCULAR

No syncope or palpitations.

SLEEP / GENERAL

Insomnia with difficulty maintaining sleep. Fatigue. Stable weight.

O Objective

15 VITAL SIGNS

BP:	128/82 mmHg	**HR:**	76 bpm	**RR:**	14/min
Temperature:	98.4°F	**O_2 Sat:**	Not recorded		

16 GENERAL PHYSICAL EXAMINATION

General appearance:	Alert, cooperative, mildly fatigued
Level of distress:	No acute distress
Signs of seizure-related trauma:	Healed scalp scar over left parietal region
Gait:	Normal

17 NEUROLOGICAL EXAMINATION

MENTAL STATUS

DOMAIN	FINDINGS
Orientation & alertness	Alert and oriented ×3
Attention & memory	Intact attention and concentration
Language	Mild word-finding difficulty noted
Mood & affect	Mildly anxious, appropriate

CRANIAL NERVES (I–XII)

CN I–XII intact. Normal visual fields and extraocular movements. Symmetric facial movements.

MOTOR EXAMINATION

FINDING	DETAILS
Muscle strength (0–5 scale)	5/5 throughout
Muscle tone & bulk	Normal tone and bulk
Focal deficits	None

SENSORY EXAMINATION

Intact to light touch, vibration, and proprioception.

REFLEXES

REFLEX	RIGHT	LEFT
Biceps	2+	2+
Triceps	2+	2+
Brachioradialis	2+	2+
Patellar	2+	2+
Achilles	2+	2+
Babinski / Clonus	Absent	Absent

COORDINATION & GAIT

TEST	FINDINGS
Finger-to-nose	Normal
Heel-to-shin	Normal
Rapid alternating movements	Normal
Balance & gait	Normal gait
Romberg test	Negative

18 DIAGNOSTIC STUDIES

ELECTROENCEPHALOGRAPHY (EEG)

Right temporal epileptiform discharges. Intermittent focal slowing.

NEUROIMAGING

MRI brain: Right mesial temporal sclerosis. No tumours or vascular abnormalities.

LABORATORY STUDIES

Electrolytes within normal limits. Toxicology screen negative. No metabolic abnormalities.

A Assessment

19 CLINICAL SUMMARY

32-year-old male with focal epilepsy likely originating in the right temporal lobe, characterised by focal impaired awareness seizures progressing to bilateral tonic-clonic seizures. Increasing frequency suggests suboptimal seizure control, likely multifactorial (medication non-adherence, sleep deprivation).

20 PRIMARY DIAGNOSIS

Diagnosis: Focal epilepsy with secondary generalisation

Epilepsy aetiology: Structural — mesial temporal sclerosis (right)

21 DIFFERENTIAL DIAGNOSIS

1. Psychogenic non-epileptic seizures (less likely given EEG findings) 2. Syncope (unlikely) 3. Sleep disorder-related events.

22 RISK ASSESSMENT

Seizure recurrence risk: High

SUDEP risk / other complications: Elevated SUDEP risk due to uncontrolled seizures; moderate injury risk

P Plan

23 MEDICAL MANAGEMENT

Increase levetiracetam to 1500mg BID. Consider transition to lamotrigine if mood side effects persist. Reinforce strict medication adherence. Continue intranasal midazolam rescue therapy.

24 DIAGNOSTIC PLAN

Prolonged video EEG monitoring. Repeat MRI if clinical progression noted.

25 NON-PHARMACOLOGIC MANAGEMENT

Emphasise 7–8 hours of sleep nightly. Stress management strategies. Avoid alcohol and known triggers.

26 SEIZURE SAFETY COUNSELLING

No driving until seizure-free per state law. Avoid swimming alone. Avoid operating heavy machinery. Implement home safety measures.

27 SURGICAL EVALUATION

Refer to epilepsy surgery programme for evaluation. Consider temporal lobectomy if drug-resistant epilepsy confirmed.

28 SEIZURE MONITORING

Maintain detailed seizure diary. Use wearable seizure detection device.

29 PATIENT EDUCATION

Discussed nature of epilepsy and prognosis. Importance of adherence and trigger avoidance. Educated on seizure first aid. Reviewed warning signs requiring ER evaluation.

30 FOLLOW-UP

Return in: 6 weeks (neurology clinic)

Earlier if: Seizure frequency increases or medication side effects worsen

Notes: Seizure diary to be reviewed at next visit

PROVIDER SIGNATURE

Provider name: Dr. Daniel R. Weiss, MD

Date & Time: 04/01/2026

Credentials / NPI: MD, Epileptology

Signature: