



## Canine epilepsy questionnaire

Date: \_\_\_\_\_

### 1. General Questions:

Owner's name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

e-mail: \_\_\_\_\_

### 2. Dog's information

Call name: \_\_\_\_\_

Register name: \_\_\_\_\_

Register number and breed: \_\_\_\_\_

Name of the breeder: \_\_\_\_\_

Date of birth: \_\_\_\_\_

Dog's weight: \_\_\_\_\_

Gender: \_\_\_\_\_

Is dog alive ?

Yes

No; Reason of death: \_\_\_\_\_

\_\_\_\_\_ Age of death: \_\_\_\_\_

(We hope you would answer in all of the question, even if the dog is dead)

Is the dog neutered?

Yes, date of neutering? \_\_\_\_\_

No

Is your dog working dog or active in sports?

Yes; Please specify? \_\_\_\_\_

No

Do you have other animals?

Yes, Which animals? \_\_\_\_\_

No

**How would you describe your dog's character?**

- Lively  
 Cheerful  
 Calm  
 In low spirits  
 Nervous  
 Shy  
 Aggressive  
 Other, what? \_\_\_\_\_

**Does your dog live indoors or outdoors?** \_\_\_\_\_

**How many hours in a calendar day your dog is in your company or in a company of your family member (the time in which you would be able to observe the possible seizures)?**

- Less than 5 hours/calendar day  
 5-10 hours/calendar day  
 10-15 hours/calendar day  
 15-20 hours/calendar day  
 yli 20 hours/calendar day

### 3. General Questions about your dog's epilepsy

**Age of seizure onset (Please, be as accurate as you can)**

\_\_\_\_\_

**Most recent seizure date:** \_\_\_\_\_

\_\_\_\_\_

**How many seizures has your dog had so far?** \_\_\_\_\_

**Average time between seizures in the beginning of disease?**

- \_\_\_\_\_ times a day  
 \_\_\_\_\_ times a week  
 \_\_\_\_\_ times a month  
 \_\_\_\_\_ times a year

**Has the duration and intensity of the seizures (after the beginning of the disease)**

- remarkably diminished?  
 diminished to some extent?  
 remained the same?  
 increased?  
 remarkably increased?

**How long was the time period between the first seizure and beginning of the medication?**

- \_\_\_\_\_ days  
 \_\_\_\_\_ weeks  
 \_\_\_\_\_ months  
 \_\_\_\_\_ years  
 Medication began immediately after the first seizure  
 The dog has no medication

**Are there any triggers you can identify that seem to predispose to the seizures?**

- Stress  
 Sexual activity  
 Weather  
 Certain time of day, which? \_\_\_\_\_  
 Certain season of year, which? \_\_\_\_\_  
 No predisposing factors  
 Other predisposing factors, which? \_\_\_\_\_
- 

**If your dog is neutered, did the neutering diminish the seizures?**

- Yes, the seizures diminished clearly  
 Yes, the seizures diminished some  
 Neutering had no effect  
 No, the seizures increased after neutering

**Does your dog act completely normally between the seizures?**

- Yes  
 No; what is the difference to the normal behaviour? \_\_\_\_\_
- 

**Have the seizures affected dog's normal behaviour?**

- Yes; How? \_\_\_\_\_  
 No

**Has your dog ever had more than one seizure in 24 hours?**

- Yes  
 No

If you answered yes, how many seizures has your dog had in 24 hours?

At least \_\_\_\_\_ seizures

In average \_\_\_\_\_ seizures

At most \_\_\_\_\_ seizures

**Does your dog have relatives with epilepsy?**

- Yes  
 I don't know  
 No

**Please, list here the epileptic relatives of your dog you are aware of (preferably with register names)**

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## 4. Seizures

### a) Pre-ictal phase / Prodrome

**Period of time: hours to days before the seizure.**

**In what kind of situations does your dog usually have the seizures?**

- In rest
- In asleep
- Awake in normal activity
- In physical stress
- After physical stress
- In mental stress
- When your dog misses you
- After a meal
- After having not eaten for a long time
- When he/she is sick
- In an intense state of feeling (in aggression, fight etc.)
- Seizures happen usually in random situations without any connection to certain states of feeling

**Can you predict in advance if your dog is going to have a seizure?**

- Yes
- No (*Please, skip to part b*)

**What symptoms/changes in normal behaviour does your dog show before the seizure?**

- Nausea
  - Vomiting
  - Salivation/drooling
  - Dog is restless
  - The dog seeks for contact to the owner
  - The dog becomes aggressive
  - Other; What? \_\_\_\_\_
- 

**How long before the seizure you are able to see these symptoms?**

- less than 30 min
- 30-60 min
- 1-2 hours
- 2-6 hours
- 6-12 hours
- 12-24 hours
- 1-2 days
- yli 2 days

**How often can predict your dog having a seizure?**

- Never
  - 25% of cases
  - 50% of cases
  - 75% of cases
  - Every time
- 

### b) Seizure / Ictal phase

**Ictal phase is the time during the seizure and immediately before it starts.**

**Have you ever observed your dog experiencing a seizure?**

- Yes  
 No

**Have you ever observed a seizure in its entirety from beginning to end?**

- Yes  
 No

**What does your dog do immediately before the seizure?**

- Sleeps  
 Is awake  
 Is having a walk outside  
 Plays  
 Exercises sports with his owner  
 Other; what? \_\_\_\_\_

**Could you describe in detail the time immediately before the seizure starts?**

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**Have you ever tried to call your dog by name or to take contact with him right before the seizure starts?**

- Yes  
 No

**If you answered yes to the previous question, please describe the state of the dog's consciousness?**

- Fully normal (*reacts normally to speech*)  
 Abnormal, but not fully absent (*reacts to speech or touching in some way*)  
 Fully absent (*is not responding in any way to speech or touching*)

**Approximately how long does a single seizure last? (ignore the pre- and post ictal phases)**

Usually the seizure lasts approx. \_\_\_\_\_ minutes  
 The shortest seizure lasted approx. \_\_\_\_\_ minutes  
 The longest seizure lasted approx. \_\_\_\_\_ minutes

**Description of the seizure:**

**Estimate how typical the following options are in a case of your dog's seizures. (Please, answer all questions).**

**In the box preceding the description of symptom, please number the actual order of symptoms appearing. If more than one symptom occurs simultaneously, you may use the same number.**

- |  |                                 |                                |                                 |                                |
|--|---------------------------------|--------------------------------|---------------------------------|--------------------------------|
| <input type="checkbox"/> Stiffening of neck and limbs  | <input type="checkbox"/> Always | <input type="checkbox"/> Often | <input type="checkbox"/> Seldom | <input type="checkbox"/> Never |
| <input type="checkbox"/> Falling                       | <input type="checkbox"/> Always | <input type="checkbox"/> Often | <input type="checkbox"/> Seldom | <input type="checkbox"/> Never |
| <input type="checkbox"/> Muscle fasciculation          | <input type="checkbox"/> Always | <input type="checkbox"/> Often | <input type="checkbox"/> Seldom | <input type="checkbox"/> Never |
| <input type="checkbox"/> Tremor                        | <input type="checkbox"/> Always | <input type="checkbox"/> Often | <input type="checkbox"/> Seldom | <input type="checkbox"/> Never |
| <input type="checkbox"/> Twisting head                 | <input type="checkbox"/> Always | <input type="checkbox"/> Often | <input type="checkbox"/> Seldom | <input type="checkbox"/> Never |
| <input type="checkbox"/> Twisting facial muscles       | <input type="checkbox"/> Always | <input type="checkbox"/> Often | <input type="checkbox"/> Seldom | <input type="checkbox"/> Never |
| <input type="checkbox"/> Urination                     | <input type="checkbox"/> Always | <input type="checkbox"/> Often | <input type="checkbox"/> Seldom | <input type="checkbox"/> Never |
| <input type="checkbox"/> Defecation                    | <input type="checkbox"/> Always | <input type="checkbox"/> Often | <input type="checkbox"/> Seldom | <input type="checkbox"/> Never |
| <input type="checkbox"/> Temporary ceace in breathing  | <input type="checkbox"/> Always | <input type="checkbox"/> Often | <input type="checkbox"/> Seldom | <input type="checkbox"/> Never |
| <input type="checkbox"/> Drooling                      | <input type="checkbox"/> Always | <input type="checkbox"/> Often | <input type="checkbox"/> Seldom | <input type="checkbox"/> Never |
| <input type="checkbox"/> Dilation of pupils            | <input type="checkbox"/> Always | <input type="checkbox"/> Often | <input type="checkbox"/> Seldom | <input type="checkbox"/> Never |
| <input type="checkbox"/> Chewing                       | <input type="checkbox"/> Always | <input type="checkbox"/> Often | <input type="checkbox"/> Seldom | <input type="checkbox"/> Never |
| <input type="checkbox"/> Change posture                | <input type="checkbox"/> Always | <input type="checkbox"/> Often | <input type="checkbox"/> Seldom | <input type="checkbox"/> Never |
| <input type="checkbox"/> Chasing tail                  | <input type="checkbox"/> Always | <input type="checkbox"/> Often | <input type="checkbox"/> Seldom | <input type="checkbox"/> Never |
| <input type="checkbox"/> Moving in circles             | <input type="checkbox"/> Always | <input type="checkbox"/> Often | <input type="checkbox"/> Seldom | <input type="checkbox"/> Never |
| <input type="checkbox"/> Temporary unconsciousness     | <input type="checkbox"/> Always | <input type="checkbox"/> Often | <input type="checkbox"/> Seldom | <input type="checkbox"/> Never |
| <input type="checkbox"/> Staring                       | <input type="checkbox"/> Always | <input type="checkbox"/> Often | <input type="checkbox"/> Seldom | <input type="checkbox"/> Never |
| <input type="checkbox"/> Trying to get near people     | <input type="checkbox"/> Always | <input type="checkbox"/> Often | <input type="checkbox"/> Seldom | <input type="checkbox"/> Never |
| <input type="checkbox"/> Bumping into furniture's etc. | <input type="checkbox"/> Always | <input type="checkbox"/> Often | <input type="checkbox"/> Seldom | <input type="checkbox"/> Never |
| <input type="checkbox"/> Temporary loss of vision      | <input type="checkbox"/> Always | <input type="checkbox"/> Often | <input type="checkbox"/> Seldom | <input type="checkbox"/> Never |
| <input type="checkbox"/> Barking                       | <input type="checkbox"/> Always | <input type="checkbox"/> Often | <input type="checkbox"/> Seldom | <input type="checkbox"/> Never |
| <input type="checkbox"/> Fear                          | <input type="checkbox"/> Always | <input type="checkbox"/> Often | <input type="checkbox"/> Seldom | <input type="checkbox"/> Never |
| <input type="checkbox"/> Aggressiveness                | <input type="checkbox"/> Always | <input type="checkbox"/> Often | <input type="checkbox"/> Seldom | <input type="checkbox"/> Never |

**Are your dog's seizures all alike?**

- Yes  
 No

**Have you ever had the impression that one part or side of his/her body behaves differently from the rest of his/her body during a seizure? For example twisting more strongly etc.**

- Yes; How? \_\_\_\_\_  
 No

**Have you been able to influence in the way the seizure proceeds?**

- Yes; How? \_\_\_\_\_  
 No
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**c) post-ictal phase**

period of time: minutes to hours to days after the seizure

**Do you think your dog realizes what has happened after a seizure?**

Yes

No

**Why?** \_\_\_\_\_

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**Are you afraid of his/her reactions after a seizure?**

Yes

No

**Why?** \_\_\_\_\_

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**Can he/she respond when you call his/her name after a seizure?**

Yes

No

**Have you ever asked him/her to do a task after a seizure?**

Yes

No

**If yes, what happened?**

The dog obeys normally

The dog obeys, but acts abnormally

The dog doesn't obey

**Please describe anything you notice in the minutes, hours and days after a seizure, and when this occurs relative to the seizure.**

Dog is tired

Dog wanders around

Dog is aggressive

Dog drinks

Dog eats

Dog wants to go out

Dog don't want to get up

Dog is vomiting or retching

Else, what? \_\_\_\_\_

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**How long does your dog take to return to normal after a seizure?**

Less than 5 minutes

5-15 minutes

15-30 minutes

30-60 minutes

1-2 hours

2-6 hours

yli 6 hours

The dog behaves normally right after the seizure

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## 5. Veterinarian's clinical tests and dogs health condition

Has a veterinarian diagnosed your dog with epilepsy?

Yes

No

Where any additional clinical tests made when the diagnosis was done?

Blood test  Yes  No

Electro-encephalogram (EEG)  Yes  No

Scan with cerebrospinal fluid (CSF)  Yes  No

Computerized tomography(CT) or  
magnetic resonance imaging (MRI)  Yes  No

Other clinical investigations  Yes  No

If yes; what? \_\_\_\_\_

Does your dog currently have any other serious health problems besides seizures?

Yes; what? \_\_\_\_\_

No

Other relevant medical history:

Yes; what? \_\_\_\_\_

No

### Questions for female dogs

What was your dog's age when she was in heat at the first time? \_\_\_\_\_

Is she in heat regularly (if she is sterilized, was she regular before that)?

Yes \_\_\_\_\_

No

Has your dog been with pups?

Yes \_\_\_\_\_

No

If yes, how many litters has she had? \_\_\_\_\_

### Questions for male dogs

Does your dog show normal sexual behavior?

Yes

No; How is it abnormal? \_\_\_\_\_

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Does your dog have offspring?

( ) Yes, How many litters? \_\_\_\_\_  
 ( ) No

**Do you have knowledge of your dog's birth?**

( ) Yes  
 ( ) No (*Skip to part epilepsy medication*)

**What was your dog's birth weight ?** \_\_\_\_\_

**Did your dog need special help from human during the first weeks of his life ?**

( ) Yes \_\_\_\_\_  
 ( ) No

**Were there any difficulties related to your dog's birth?**

( ) Yes  
 ( ) No; What? \_\_\_\_\_

## **Epilepsy medication**

**Is your dog taking any medication, supplements or other treatments to control the seizures?**

( ) Yes  
 ( ) No

**When did you start giving the medication?** \_\_\_\_\_

**Current medication(s):**

**Medicine 1:** \_\_\_\_\_ **Medicine 2:** \_\_\_\_\_

**Dosage 1:** \_\_\_\_\_ **Dosage 2:** \_\_\_\_\_

**How often does he get medicine 1?**

( ) Once a day  
 ( ) Twice a day  
 ( ) Three times a day  
 ( ) Four times a day

**How often does he get medicine 2?**

( ) Once a day  
 ( ) Twice a day  
 ( ) Three times a day  
 ( ) Four times a day

**Does your dog receive the medicine(s) routinely?**

( ) Yes  
 ( ) No; Why and on what basis is he getting the medicine? \_\_\_\_\_

**Have the blood levels of the medicine(s) been taken?**

( ) Yes; results: \_\_\_\_\_  
 ( ) I don't know  
 ( ) No

**How effective has the medication been in controlling the seizures?**

( ) The medication has stopped the seizures completely  
 ( ) The medication has reduced the number of seizures in half  
 ( ) The medication has reduced the number of seizures a little  
 ( ) The medication has not reduced the number of seizures at all

**Has the medication eased off the seizures?**

( ) Yes; How? \_\_\_\_\_  
 ( ) No

**Does the medication affect your dog’s working abilities?**

- Yes
- No

**Do you medicate your dog during the seizures?**

- Yes, What medicine and what dosage? \_\_\_\_\_
- No

**Have you noticed the medicine to have any side effects?**

- I haven’t noticed any side effects
- Sleepiness
- Vomiting
- Increased drinking
- Staggering
- Else, What? \_\_\_\_\_

**Have you been giving any herbal treatments, nutritional supplements, or other therapies for the epilepsy, please list them below.**

- Yes
- No

**If yes; what treatments and for how long? Have you noticed any results? \_\_\_\_\_**

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**7. Other**

**If you have any additional information which you think might be useful, include them below**

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**Please return by email or mail to:**

**Ranja Eklund/Lohi’s Lab  
 Biomedicum Helsinki, Room B336b  
 P.O.Box 63 (Haartmaninkatu 8)  
 00014 University of Helsinki  
 tel. 09-191 25085  
 ranja.eklund@helsinki.fi**

**Thank you for helping with this important research. With your help, we hope to better understand epilepsy in dogs and improve our ability to prevent and treat this devastating disease.**