Patient Name **No.**

Name	Date of birth (Age) / /	Male ( ) Female ( )	Normal Delivery( ) Assisted ND ( ) Caesarian section( )	preterm Yes ( ) No ( ) Weeks ( )
Full term Yes ( ) No ( )	Antenatal Fever& rash Yes ( ) No ( )	Maternal chronic illness Yes ( ) No ( ) Type ( )	Maternal Drugs Yes ( ) No ( )	Type of M. drugs
Family H/O febrile seizure Yes ( ) No ( )	Family H/O CNS disorder Yes ( ) No ( )	Age of First Attack ( ) months	Focal neurological signs Yes ( ) No ( )	Recurrent F.fits Yes ( ) No ( )
Any chronic illness Yes ( ) No ( ) Type ( )	Type of treatment ( ) Duration ( )	No. of Admissions to Hospital ( )	CSF Study Yes ( ) No ( ) Result ( )	Otitis media Yes ( ) No ( ) Recurrent( )
Suppurative O.M Yes ( ) No ( )	ENT Visit &treatment Yes ( ) No ( )	O.M Treatment Yes ( ) No ( )	Type of O.M Treatment ( )	Siblings with F.Fit Yes ( ) No ( )
Siblings with H/O O.M Yes ( ) No ( )	Type of Feeding Breast F. ( ) Bottle F. ( ) Mixed F. ( )	Pacifier Use Yes ( ) No ( ) Duration ( )	Meningitis Yes ( ) No ( ) Type ( )	Delay in mile stones Yes ( ) No ( )
Financial problem Yes ( ) No ( )	Social problem Yes ( ) No ( )	Nursery care Yes ( ) No ( )	Rural area Yes ( ) No ( )	Urban area Yes ( ) No ( )