



Date: Time Of Episode:

AFFECTED MUSCLES
☐ Legs ☐ Arms ☐ Face ☐ Others (specify):

EPISODE LENGTH
☐ <1hr ☐ 1-4hrs ☐ 4-10hrs ☐ >10hrs

HOSPITALIZATION REQUIRED? ☐ YES ☐ NO

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PPP MONTHLY OVERVIEW FOR:

(Days)

(Month)

(Year)

Patient name:

Date Of Birth:

Current Doctor and Clinic:

Diagnosis:

☐

Hypokalemic PP

☐

Hyperkalemic PP

☐

Other type of PPP; specify:

Family history:

☐

YES

☐

NO

Total number of episodes:

Number of hospitalizations:

Commonly affected muscles:

☐

Legs

☐

Arms

☐

Face

☐

Others (specify):

Overall satisfaction level with the treatment:

☐

Not satisfied

☐

Somewhat satisfied

☐

Satisfied

☐

Very satisfied

Please explain your above choice:

How would you rate your quality of life:

☐

Poor

☐

Somewhat Poor

☐

Average

☐

Good

☐

Very good

Please explain your above choice:

Do you have any questions for the doctor?

1:

2:

3:

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