SEIZURES

How often are you having seizures? Please check one and fill in the blank where appropriate.

☐ _____ times per month  ☐ _____ times per year
☐ _____ times per day    ☐ _____ times per week
☐ I don’t know

What time of day do your seizures occur? Please check all that apply.

☐ Morning  ☐ Afternoon  ☐ Nighttime

How long do your seizures normally last?
_________________________________________________________

Do you experience any of the following symptoms while having a seizure? Please check all that apply.

☐ Muscle jerking  ☐ Strong sense of déjà vu
☐ Seeing, smelling, tasting, hearing, or feeling things that aren’t there  ☐ Muscle stiffening
☐ Confusion  ☐ Repetitive behaviors
☐ Convulsions  ☐ Involuntary muscle movements
☐ Aura  ☐ Loss of consciousness
☐ Other: ________________

TREATMENT

On a scale of 1 to 10, how well is your current epilepsy medicine(s) working? Please circle one.

1 2 3 4 5 6 7 8 9 10
(not working)  (working extremely well)

What side effects (if any) are you experiencing with your current epilepsy medicine(s)? Please check all that apply.

☐ Dizziness  ☐ Sleepiness
☐ Headache  ☐ Behavior changes
☐ Double vision  ☐ Other: ________________

Since starting your current treatment, have your seizures been less frequent? Please check one.

☐ YES  ☐ NO

Have you missed any doses lately? Please check one.

☐ YES  ☐ NO  ☐ I don’t know

If yes, why? __________________________
If so, how often? ______________________

EMOTIONAL IMPACT

Have you noticed any changes in mood because of epilepsy? Please check one.

☐ YES  ☐ NO
If so, please describe those changes.
_________________________________________________________

Have seizures affected your relationships with your partner, family, friends, or others? Please check one.

☐ YES  ☐ NO

Have seizures interfered with your ability to hold a job or go to school? Please check one.

☐ YES  ☐ NO

If seizures are affecting your emotions, would you like any resources to help you cope?

☐ YES  ☐ NO

If yes, what kind of resources would be helpful?
_________________________________________________________

PERSONAL GOALS

To help achieve those goals, would you be interested in adding to or switching your epilepsy medicine(s)? Please check one.

☐ YES  ☐ NO

What’s your overall goal for today’s visit?
_________________________________________________________

What are your overall goals for the next year?
_________________________________________________________

SAFETY

Does epilepsy hold you back in your everyday activities? Please check one.

☐ YES  ☐ NO

If yes, which activities are you being held back from?
_________________________________________________________

Do you take the necessary safety precautions when doing everyday activities? If so, what are they?
_________________________________________________________

Are you aware of sudden unexpected death in epilepsy (SUDEP)? Please check one.

☐ YES  ☐ NO

Be aware of the following safety precautions: follow physician guidance and state laws regarding driving; take showers, not baths; don’t swim alone; don’t climb heights; avoid operating dangerous machinery.

ALWAYS SHARE YOUR CONCERNS ABOUT EPILEPSY WITH YOUR DOCTOR. TOGETHER, YOU CAN CREATE A TREATMENT PLAN THAT WORKS FOR YOU.