Epilepsy Can Be Life-Threatening: Preparing to Talk to Your Doctor

Fill out this form and bring a printed copy to your neurologist visits. Be sure to keep an electronic or paper copy for yourself—this will be a valuable tool in assessing serious or life-threatening risks associated with epilepsy and working with your doctor to decrease the risks.

What is currently your primary type of seizure? _____

_____

Note: Seizure types include Generalized Seizures (tonic-clonic, clonic, tonic, myoclonic, atonic, epileptic spasms, absence), Focal Seizures (focal with impaired awareness, focal aware, and epileptic spasms), and Infantile Spasms.

If you experience other seizure types, list them here: _____

_____

When was the last seizure?_____

At what age did the seizures begin? _____ Years _____ Months

How often do you typically have seizures? (check one)

☐ Yearly ☐ Monthly ☐ Weekly ☐ Daily

How many minutes do the seizures usually last? _____ minutes

Is there a known trigger(s)? (check one)

☐ Yes ☐ No ☐ Don't Know

If yes, what triggers the seizures? _____

_____

Is there a known warning sign(s)? (check one)

☐ Yes ☐ No ☐ Don't Know

If yes, what is the warning sign?_____

_____

What time of day are the seizures? (check one)

☐ Morning ☐ Midday ☐ Afternoon ☐ Evening ☐ During Sleep

Have you noticed a recent change in your seizure type or frequency? (check one)

☐ Yes ☐ No ☐ Don't Know

Do you have a seizure action plan? (check one)

☐ Yes ☐ No ☐ Don't Know

If yes, please describe:_____

_____

Do you take your medication as prescribed? (check one)

☐ Always

☐ Very Often

☐ Sometimes

☐ Rarely

☐ Never

If not always, explain why: _____

_____

Are there any side effects from the medications? (check one)

☐ Yes ☐ No ☐ Don't Know

If yes, please describe:_____

_____

Have you started any new medications since your last visit? (check one)

☐ Yes ☐ No ☐ Don't Know

Is your doctor aware of all medications you are currently taking? (check one)

☐ Yes ☐ No ☐ Don't Know

Have you had any major illnesses or visits to the emergency room or urgent care in the past year? (check one)

☐ Yes ☐ No ☐ Don't Know

If yes, please describe:_____

_____

Have you been diagnosed with the following? (check all that apply)

☐ Heart disease ☐ Kidney disease

☐ Liver disease ☐ Lung disease

☐ Cancer ☐ Diabetes

☐ Other_____

If you selected any of the above, please describe:_____

_____

How many hours do you typically sleep at night? _____ hours

Are you satisfied with your sleep? (check one)

☐ Yes ☐ No

What hobbies do you participate in? (e.g., art, sports, etc.) _____

What is your profession? _____

Do you typically do any of the following? (check as many as apply)

- ☐ Take baths without supervision
- ☐ Swim without supervision
- ☐ Approach open flames, such as candles, fireplaces, campfires, etc.
- ☐ Use ladders or other activities that might increase the risk of falling
- ☐ Bicycle or engaging in contact sports without wearing a helmet
- ☐ Trip or fall in your home or at work
- ☐ Use heavy equipment, including driving cars

Do you spend time in a home where a gun is kept? (check one)

☐ Yes ☐ No

Have you experienced any of the following? (check as many as apply)

- ☐ Loss of health coverage
- ☐ Significant household changes
  - ☐ Getting married or divorced
  - ☐ Having a baby or adopting a child
  - ☐ Death in the family
  - ☐ Other _____
- ☐ Changes in residence
  - ☐ Moving to a different home (including a student moving to or from school)
  - ☐ Moving to or from a shelter or other transitional housing
- ☐ Beginning puberty
- ☐ Difficulty attending school or work
- ☐ Other stressful situations

During the past two weeks, how often have you been bothered by the following problems:

Feeling down, depressed, irritable, or hopeless? (check one)

☐ Not at all ☐ Several days
☐ More than half the day ☐ Nearly every day

Little interest or pleasure in doing things? (check one)

☐ Not at all ☐ Several days
☐ More than half the day ☐ Nearly every day

TO LEARN MORE:

Visit **preventingepilepsydeaths.org** for information.

Ask your **doctor** how to decrease your risk of dying from epilepsy.

Connect with **advocacy organizations** to learn more about epilepsy and join a supportive community.