

# My Health Record

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You may complete this form right here on your computer screen and either save it to your desktop or print it out. You can also just print the questions and fill them out by hand.

Discuss this information with your neurologist or epileptologist at your next appointment. Your answers will give your doctors valuable details about your seizures.

## Your Seizure Management Plan

Are you completely happy with your current epilepsy treatment? Yes  No

Do you still have seizures? Yes  No

How often do you have seizures? \_\_\_\_\_

What medicines are you using to treat your epilepsy? \_\_\_\_\_

\_\_\_\_\_

What other medicines are you taking? \_\_\_\_\_

\_\_\_\_\_

Are you taking birth control pills or hormone replacement therapy? Yes  No

What supplements or herbal medicines are you taking? \_\_\_\_\_

\_\_\_\_\_

## Your Seizures

What type of seizures do you have? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Do you have convulsions? Yes  No

Are your seizures milder, about the same, or worse than ones you have had in the past?

Milder  About the same  Worse

What time of day do your seizures occur (for example, always at night)? \_\_\_\_\_  
\_\_\_\_\_

Do your seizures take place slowly or quickly? Slowly  Quickly

Before the seizures, are you...?

- |  |                                    |
|--|------------------------------------|
| <input type="checkbox"/> Dizzy         | <input type="checkbox"/> Thirsty   |
| <input type="checkbox"/> Faint         | <input type="checkbox"/> Hot       |
| <input type="checkbox"/> Out of breath | <input type="checkbox"/> Emotional |
| <input type="checkbox"/> Very tired    | <input type="checkbox"/> Sick      |
| <input type="checkbox"/> Hungry        |                                    |

Other (Please specify.) \_\_\_\_\_  
\_\_\_\_\_

Do you have any other warning that a seizure is about to happen? Yes  No

(Please specify.) \_\_\_\_\_  
\_\_\_\_\_

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Is there one particular type of event that appears to cause your seizure? Yes  No

*(Please specify.)* \_\_\_\_\_

Are any of the following affected during your seizures?

- |                                   |   |
|-----------------------------------|---|
| <input type="checkbox"/> Speech   | <input type="checkbox"/> Hearing          |
| <input type="checkbox"/> Movement | <input type="checkbox"/> Memory           |
| <input type="checkbox"/> Vision   | <input type="checkbox"/> Bodily functions |

During the seizure, did you...? *(Ask a friend or family member to help you complete this section.)*

- |   |   |
|---|---|
| <input type="checkbox"/> Stare                                | <input type="checkbox"/> Lose consciousness                 |
| <input type="checkbox"/> Feel confused                        | <input type="checkbox"/> Vomit                              |
| <input type="checkbox"/> Become dizzy                         | <input type="checkbox"/> Lose control of your urine         |
| <input type="checkbox"/> Have numbness or tingling sensations | <input type="checkbox"/> Shake                              |
| <input type="checkbox"/> Say or do anything                   | <input type="checkbox"/> Have arm movements or muscle jerks |
| <input type="checkbox"/> Fall to the ground                   | <input type="checkbox"/> Cry out                            |
| <input type="checkbox"/> Bite your tongue                     |   |

Other *(Please specify.)* \_\_\_\_\_

After the seizures, do you experience...?

- Tiredness
- Muscle weakness
- Headache

Other *(Please specify.)* \_\_\_\_\_

## Your Daily Life

How many hours of sleep do you get on an average night? \_\_\_\_\_

Are there any nights when you get less than 6 hours of sleep? Yes  No

Have you recently been under any more stress than usual? Yes  No

How many alcoholic drinks (beer, wine, mixed drinks) do you have in an average week? \_\_\_\_\_

Do you smoke cigarettes? Yes  No

How many per day? \_\_\_\_\_

## Epilepsy Medicine Side Effects

A medicine's side effects are different for different people. The following list includes many of the common side effects of epilepsy treatments. Having one of these does not mean that it was caused by your epilepsy medicine—but you should discuss any of these with your neurologist:

**Please check all of the boxes that apply to you.**

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Irritability             | <input type="checkbox"/> Inability to sleep            | <input type="checkbox"/> Double or blurred vision          |
| <input type="checkbox"/> Psychotic episodes       | <input type="checkbox"/> Fatigue                       | <input type="checkbox"/> Memory loss                       |
| <input type="checkbox"/> Depression               | <input type="checkbox"/> Weight gain or loss           | <input type="checkbox"/> Uncontrolled body movement        |
| <input type="checkbox"/> Restless feelings        | <input type="checkbox"/> Acne                          | <input type="checkbox"/> Difficulty finding the right word |
| <input type="checkbox"/> Feelings of loneliness   | <input type="checkbox"/> Change in hair growth or loss | <input type="checkbox"/> Digestive problems                |
| <input type="checkbox"/> Hopeless feelings        | <input type="checkbox"/> Trouble with mouth or gums    | <input type="checkbox"/> Nausea                            |
| <input type="checkbox"/> Difficulty concentrating | <input type="checkbox"/> Coordination problems         | <input type="checkbox"/> Tremors                           |
| <input type="checkbox"/> Nervousness or agitation | <input type="checkbox"/> Vertigo/dizziness             | <input type="checkbox"/> Irregular menstruation            |
|   |  | <input type="checkbox"/> Other                             |