

When did you have your most recent epileptic seizure? (Write year and month - write "?" if you do not remember)

Year (f. ex. 2011)::

Month no. (f. ex. 11):

How many seizures did you have last year? (if none, write 0)

Number of attacks: :

How many absence seizures have you had in the last 3 months?

Number of attacks: :

How many generalized seizures (convulsions) have you had during the last 3 months?

Number of attacks: :

Answer the following questions only if you have had at least 1 epileptic seizure during the last year

Do your epileptic seizures occur during sleep?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Are your seizures getting worse?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Have you sustained an injury during a seizure?	<input type="checkbox"/> No	<input type="checkbox"/> Yes, but not a serious one	<input type="checkbox"/> Serious damage (f. ex. bone fracture, cut wounds)
Have you been in contact with an emergency room because of epilepsy since your last visit to the outpatient department?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	

Are your relatives worried about you because of your epilepsy?

Put one tick	<input type="checkbox"/> Never	<input type="checkbox"/> Rarely	<input type="checkbox"/> Occasionally	<input type="checkbox"/> Frequently	<input type="checkbox"/> Do not know	<input type="checkbox"/> Not applicable
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During the last 4 weeks to what degree have you suffered from:

Headache	<input type="checkbox"/> Never	<input type="checkbox"/> Occasionally	<input type="checkbox"/> Sometimes	<input type="checkbox"/> Often	<input type="checkbox"/> Very often
Dizziness	<input type="checkbox"/> Never	<input type="checkbox"/> Occasionally	<input type="checkbox"/> Sometimes	<input type="checkbox"/> Often	<input type="checkbox"/> Very often
Tremor/shaking	<input type="checkbox"/> Never	<input type="checkbox"/> Occasionally	<input type="checkbox"/> Sometimes	<input type="checkbox"/> Often	<input type="checkbox"/> Very often
Double vision or other visual disturbances	<input type="checkbox"/> Never	<input type="checkbox"/> Occasionally	<input type="checkbox"/> Sometimes	<input type="checkbox"/> Often	<input type="checkbox"/> Very often
Loss of appetite	<input type="checkbox"/> Never	<input type="checkbox"/> Occasionally	<input type="checkbox"/> Sometimes	<input type="checkbox"/> Often	<input type="checkbox"/> Very often
Eating too much	<input type="checkbox"/> Never	<input type="checkbox"/> Occasionally	<input type="checkbox"/> Sometimes	<input type="checkbox"/> Often	<input type="checkbox"/> Very often
Difficulty remembering	<input type="checkbox"/> Never	<input type="checkbox"/> Occasionally	<input type="checkbox"/> Sometimes	<input type="checkbox"/> Often	<input type="checkbox"/> Very often
Difficulty concentrating	<input type="checkbox"/> Never	<input type="checkbox"/> Occasionally	<input type="checkbox"/> Sometimes	<input type="checkbox"/> Often	<input type="checkbox"/> Very often
A feeling that you easily become aggressive	<input type="checkbox"/> Never	<input type="checkbox"/> Occasionally	<input type="checkbox"/> Sometimes	<input type="checkbox"/> Often	<input type="checkbox"/> very often
Severe fatigue	<input type="checkbox"/> Never	<input type="checkbox"/> Occasionally	<input type="checkbox"/> Sometimes	<input type="checkbox"/> Often	<input type="checkbox"/> Very often
Sadness	<input type="checkbox"/> Never	<input type="checkbox"/> Occasionally	<input type="checkbox"/> Sometimes	<input type="checkbox"/> Often	<input type="checkbox"/> Very often
Being afraid of having a new seizure during the next weeks	<input type="checkbox"/> Never	<input type="checkbox"/> Occasionally	<input type="checkbox"/> Sometimes	<input type="checkbox"/> Often	<input type="checkbox"/> Very often
Lack of interest or pleasure in sexual activity	<input type="checkbox"/> Never	<input type="checkbox"/> Occasionally	<input type="checkbox"/> Sometimes	<input type="checkbox"/> Often	<input type="checkbox"/> Very often
Have you in the last 4 weeks had suicidal thoughts?	<input type="checkbox"/> Never	<input type="checkbox"/> Occasionally	<input type="checkbox"/> Sometimes	<input type="checkbox"/> Often	<input type="checkbox"/> Very often



Please indicate for each of the five statements which is closest to how you have been feeling over the last two weeks.

Over the last two weeks

I have felt cheerful and in good spirits	<input type="checkbox"/> All of the time	<input type="checkbox"/> Most of the time	<input type="checkbox"/> More than half of the time	<input type="checkbox"/> Less than half of the time	<input type="checkbox"/> Some of the time	<input type="checkbox"/> At no time
I have felt calm and relaxed	<input type="checkbox"/> All of the time	<input type="checkbox"/> Most of the time	<input type="checkbox"/> More than half of the time	<input type="checkbox"/> Less than half of the time	<input type="checkbox"/> Some of the time	<input type="checkbox"/> At no time
I have felt active and vigorous	<input type="checkbox"/> All of the time	<input type="checkbox"/> Most of the time	<input type="checkbox"/> More than half of the time	<input type="checkbox"/> Less than half of the time	<input type="checkbox"/> Some of the time	<input type="checkbox"/> At no time
I woke up feeling fresh and rested	<input type="checkbox"/> All of the time	<input type="checkbox"/> Most of the time	<input type="checkbox"/> More than half of the time	<input type="checkbox"/> Less than half of the time	<input type="checkbox"/> Some of the time	<input type="checkbox"/> At no time
My daily life has been filled with things that interest me	<input type="checkbox"/> All of the time	<input type="checkbox"/> Most of the time	<input type="checkbox"/> More than half of the time	<input type="checkbox"/> Less than half of the time	<input type="checkbox"/> Some of the time	<input type="checkbox"/> At no time

In general, would you say your health is:

Put one tick	<input type="checkbox"/> Excellent	<input type="checkbox"/> Very good	<input type="checkbox"/> Good	<input type="checkbox"/> Fair	<input type="checkbox"/> Poor
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Compared to one year ago, how would you rate your health in general now?

Put one tick	<input type="checkbox"/> Much better now than one year ago	<input type="checkbox"/> Somewhat better now than one year ago	<input type="checkbox"/> About the same	<input type="checkbox"/> Somewhat worse now than one year ago	<input type="checkbox"/> Much worse than one year ago
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Do you have other diseases or conditions that have a greater effect on your health than your epilepsy?

- Yes
- No

The next questions deal with your medical treatment

How often do you think you have forgotten to take some of your medicine?	<input type="checkbox"/> Daily	<input type="checkbox"/> Weekly	<input type="checkbox"/> Monthly	<input type="checkbox"/> Very rarely, never
Does your epilepsy medicine have side effects?	<input type="checkbox"/> No	<input type="checkbox"/> Yes, a few	<input type="checkbox"/> Yes, some	<input type="checkbox"/> Yes, many



The next questions deal with work (being a student counts as work)

Have you felt stressed at your work in the last 12 months?	<input type="checkbox"/> No	<input type="checkbox"/> Yes, a bit	<input type="checkbox"/> Yes, a lot	<input type="checkbox"/> I'm no longer in the work force	<input type="checkbox"/> I'm out of work
How much do you now work compared with 12 months ago?	<input type="checkbox"/> I work more	<input type="checkbox"/> About the same	<input type="checkbox"/> I work less	<input type="checkbox"/> I'm no longer in the work force	<input type="checkbox"/> I'm out of work
If you work less now, is it because of your epilepsy?	<input type="checkbox"/> Yes	<input type="checkbox"/> Partly	<input type="checkbox"/> No		

Has your epilepsy put serious limitations on your life?

No

Yes, describe how:

How much alcohol do you drink on average in the course of a week? (Refers to beer, wine and spirits. If you drink less than 1 unit a week, write 0)

Write number of units:

Do you use recreational drugs? (f. ex. hash)

Put one tick	<input type="checkbox"/> Never	<input type="checkbox"/> Monthly	<input type="checkbox"/> Weekly	<input type="checkbox"/> Daily
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The next questions are only relevant for women

Are you pregnant?

Yes

No

Do you plan to get pregnant within the next 12 months?

Yes

No



