Stichting Epilepsie Instellingen Nederland

Questionnaire for epilepsy outpatients

Name:

Date of birth:

Please bring the following items with you on your first outpatients appointment:

- This completed questionnaire
- Seizure calendar or overview of seizures
- Up to date medication overview (available from your pharmacist)
- If possible: recordings of seizures on video/DVD or mobile phone

1. The neurologist needs to gain an insight into both your current and past seizures. Describe your seizures below; ask others to help you with this if necessary. For each seizure, tick the appropriate box and add an explanation where necessary.

SEIZURE TYPE 1

I have had this seizure type since:_____ (year)
This seizure typically occurs:
☐ In the morning ☐ In the evening ☐ Varied, no specific time
☐ In the afternoon ☐ At night ☐ Not any more, I used to have this seizure

Do you/Did you feel this seizure coming on?
☐ No ☐ Yes, it starts with _____

Do you/Did you lose consciousness (partly or completely) during this seizure?
☐ No ☐ Yes, always ☐ Yes, sometimes ☐ Yes, partly or briefly ☐ Don't know

Describe briefly what happens during this seizure:

_____

_____

After the seizure:
☐ You react normally and you can carry on with what you were doing before the seizure
☐ It takes some time before you can carry on with what you were doing before the seizure
☐ You are very tired and you need to sleep first

☐ Other _____

This seizure lasts about:_____minutes
This seizure occurs typically after/during (an activity): _____
I get/got this seizure:
☐ 1x ☐ 2 - 5x ☐ less than once a year ☐ 1 - 5x per year ☐ 6 - 10x per year
☐ 1 - 3x per month ☐ 1 - 3x per week ☐ 3 - 5x per week ☐ >5x per week

SEIZURE TYPE 2

I have had this seizure type since: _____ (year)
This seizure typically occurs:
☐ In the morning ☐ In the evening ☐ Varied, no specific time
☐ In the afternoon ☐ At night ☐ Not any more, I used to have this seizure

Do you/Did you feel this seizure coming on?
☐ No ☐ Yes, it starts with _____

Do you/Did you lose consciousness (partly or completely) during this seizure?
☐ No ☐ Yes, always ☐ Yes, sometimes ☐ Yes, partly or briefly ☐ Don't know

Describe briefly what happens during this seizure:

_____

_____

After the seizure:
☐ You react normally and you can carry on with what you were doing before the seizure
☐ It takes some time before you can carry on with what you were doing before the seizure
☐ You are very tired and you have to sleep first

☐ Other _____

This seizure lasts about:_____minutes
This seizure occurs typically after/during (an activity): _____
I get/got this seizure:
☐ 1x ☐ 2 - 5x ☐ less than once a year ☐ 1 - 5x per year ☐ 6 - 10x per year
☐ 1 - 3x per month ☐ 1 - 3x per week ☐ 3 - 5x per week ☐ >5x per week

SEIZURE TYPE 3

I have had this seizure type since:_____ (year)
This seizure typically occurs:
☐ In the morning ☐ In the evening ☐ Varied, no specific time
☐ In the afternoon ☐ At night ☐ Not any more, I used to have this seizure

Do you/Did you feel this seizure coming on?
☐ No ☐ Yes, it starts with _____

Do you/Did you lose consciousness (partly or completely) during this seizure?
☐ No ☐ Yes, always ☐ Yes, sometimes ☐ Yes, partly or briefly ☐ Don't know

Describe briefly what happens during this seizure:

_____

_____

After the seizure:
☐ You react normally and you can carry on with what you were doing before the seizure
☐ It takes some time before you can carry on with what you were doing before the seizure
☐ You are very tired and you need to sleep first

☐ Other _____

This seizure lasts about:_____minutes
This seizure occurs typically after/during (an activity): _____
I get/got this seizure:
☐ 1x ☐ 2 - 5x ☐ less than once a year ☐ 1 - 5x per year ☐ 6 - 10x per year
☐ 1 - 3x per month ☐ 1 - 3x per week ☐ 3 - 5x per week ☐ >5x per week

2. Are there any situations/circumstances that increase the risk of having a seizure (for example menstruation, lack of sleep, computer games, flashing lights)?

☐ Yes, namely
☐ No
☐ Don't know

Description:

_____

_____

3. Do you or people in your immediate surroundings take precautionary measures before, during and/or after the seizure?

☐ Yes, namely
☐ No

Description:

_____

_____

4. Are any injuries inflicted during a seizure?

☐ Yes, namely
☐ No

Description:

_____

_____

5. Do several seizures occur one after the other?

☐ Yes, namely
☐ No

Description: (seizure type, how long do they last and how often do they occur?)

_____

_____

6. Is there a family history and/or febrile convulsions?

☐ Yes, namely
☐ No
☐ Don't know

Description:

_____

_____

7. Has any medication been prescribed to stop lengthy seizures?

☐ Yes, namely
☐ No
☐ Don't know

Description:

_____

_____

When is this prescribed?: _____

Who applies this treatment?: _____

8.a Do the seizures cause limitations and/or inhibitions in one of the following areas? (Tick the appropriate boxes):

☐ Living (e.g. independence, safety, is the living situation appropriate?)
☐ Work (e.g. functioning, applying for jobs, absenteeism, dealing with seizures)
☐ Relation (e.g. fear, or lack of understanding on the part of the partner, children or others closely involved)
☐ Sexuality (e.g. fear of a seizure, shame, libido)
☐ Family (e.g. communication, dealing with epilepsy)
☐ School/education (e.g. choice of study, school progress, how teachers/pupils deal with epilepsy)
☐ Leisure time/sport (e.g. what is possible/what is not possible)
☐ Mobility (e.g. walking, cycling, driving a car, public transport, with or without supervision)
☐ Other, namely
☐ Not applicable

8.b Would you like to discuss one of the above topics in more detail?

☐ Yes
☐ No
☐ Maybe

9. Are you currently in contact with other care providers/medical specialists and/or are you following any therapies at the moment?

☐ No

☐ Yes, complete the table below:

Name	Profession	Hospital/organisation	Town	Since
EXAMPLE: Mr. Jones	*Neurologist*	*London Hospital*	*London*	*1999*
Ms. Brown	*Social work*	*GGZ Friesland*	*Franeker*	*2007*

10. Have you ever been in contact with other care providers /medical specialists and/or have you ever followed any therapies?

Name	Profession	Hospital/organisation	Town	Since
EXAMPLE: Mr. Jones	*Neurologist*	*London Hospital*	*London*	*1999*
Ms. Brown	*Social work*	*GGZ Friesland*	*Franeker*	*2007*

11. Have your seizures resulted in, for example, admission to a hospital, an epilepsy clinic, etc.?:

☐ No

☐ Yes, complete the table below:

Name of hospital/organisation	Town	Year

12. Please complete this if your child is still at school:

Name of school:

Town:

Education type:

Class/group:

Has your child ever repeated a class?:

Contact person at school:

Via telephone number:

Are there any learning problems at school?
If so:

Are there any behavioural problems?
If so:

Do you make use of peripatetic supervision?
If so, via which organisation?

☐ De Waterlelie

☐ Other:

13. Questions/subjects you would like to talk about during the consultation:

Thank you for completing this questionnaire.

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