S.T.E.P.S.

A Discussion Guide for Patients With Epilepsy

With the right S.T.E.P.S., you can have stronger conversations with your healthcare provider and work together to reach your goals.

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
- ☐ Seeing, smelling, tasting, hearing, or feeling things that aren't there
- ☐ Confusion
- ☐ Convulsions
- ☐ Aura
- ☐ Strong sense of déjà vu
- ☐ Muscle stiffening
- ☐ Repetitive behaviors
- ☐ Involuntary muscle movements
- ☐ 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 (not working) 2 3 4 5 6 7 8 9 10 (working extremely well)

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

- ☐ Dizziness
- ☐ Headache
- ☐ Double vision
- ☐ Sleepiness
- ☐ Behavior changes
- ☐ 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.

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For more information, visit **www.WebMD.com/EpilepsySurvey**