

A Framework for Meaningful Discussion

A tool to help discuss seizure control with your healthcare team

Your Seizure Profile

These questions will help your doctor determine how you are currently doing and what next steps might make sense for you in your treatment plan.

Seizures

1.) How many seizures/episodes are you having?

- | | |
|---|---|
| <input type="checkbox"/> Usually 1 per month | <input type="checkbox"/> Usually 1 per day |
| <input type="checkbox"/> Usually 2 or 3 per month | <input type="checkbox"/> Usually 2 or 3 per day |
| <input type="checkbox"/> Usually 1 per week | <input type="checkbox"/> 4 or more per day |
| <input type="checkbox"/> Usually 2 or 3 per week | <input type="checkbox"/> Write in response |

2.) How would you describe your seizures/episodes? *(Check all that apply.)*

- | | |
|---|--|
| <input type="checkbox"/> I have dizzy spells | <input type="checkbox"/> I stare into space and don't hear others or can't respond |
| <input type="checkbox"/> I feel nauseous | <input type="checkbox"/> I suddenly fall down |
| <input type="checkbox"/> I have a funny taste in my mouth | <input type="checkbox"/> I lose consciousness |
| <input type="checkbox"/> I hear a ringing sound | <input type="checkbox"/> My body shakes |
| <input type="checkbox"/> I feel like I'm having an out-of-body experience | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> I feel tingling in my extremities | _____ |
| | _____ |

Treatment

3.) Have you had brain surgery?

- ☐ Yes
☐ No

4.) How many anti-seizure medications are you currently taking?

- | | |
|---------------------------------|------------------------------------|
| <input type="checkbox"/> 1 to 2 | <input type="checkbox"/> 5 to 6 |
| <input type="checkbox"/> 3 to 4 | <input type="checkbox"/> 7 or more |

5.) In the past, how many medications have you tried that did not work for you?

- | | |
|---------------------------------|-------------------------------------|
| <input type="checkbox"/> 1 to 3 | <input type="checkbox"/> 7 to 9 |
| <input type="checkbox"/> 4 to 6 | <input type="checkbox"/> 10 or more |

6.) Have your anti-seizure medications caused you any problems or resulted in side effects?

- ☐ Yes
☐ No

Lifestyle

7) Do your seizures interfere with your ability to do any of the following? (Check all that apply.)

- ☐ Have a job or maintain consistent attendance at work
- ☐ Attend school or college
- ☐ Participate in social activities
- ☐ Maintain relationships with family or significant other
- ☐ Have children
- ☐ Participate in athletic activities
- ☐ Independently manage daily tasks (ie, grocery shopping, get kids to school, yard work, etc)
- ☐ Safely operate a motor vehicle
- ☐ Perform basic personal hygiene tasks (ie, take a shower, style your hair, etc)

8.) If you had fewer seizures, shorter seizures, faster recovery time following your seizures, or the ability to stop a seizure once it has started, how might your life be different?

Studies show that if your first two antiepileptic drugs don't result in seizure freedom there is a 95% chance that no drug or combination of drugs will.

When drugs alone can't control seizures, this is called Drug-Resistant Epilepsy (D.R.E.). VNS Therapy is designed for people living with D.R.E.

These questions will help you and your doctor understand your interest in new therapies beyond medication:

1) I would like to consider additional treatment options beyond more medications.

- ☐ Yes ☐ No

2) I am interested in learning more about DRE and my treatment options, including VNS Therapy.

- ☐ Yes ☐ No

3) I have already contacted a VNS Therapy Specialist.

- ☐ Yes ☐ No