

Family Study of Childhood Absence Epilepsy Questionnaire

For participants WITH Epilepsy

Please fill out **one** questionnaire for **each** member of your immediate family (including those with and without epilepsy). **If you have not been diagnosed with epilepsy, please use our other questionnaire.** Parents should fill out questionnaire for children. Please contact Dana Politis or Sandy Wrigley, our Study Coordinators, if you have any questions (call **Toll-free** at **877-223-5900**). Thank you for your participation. **Feel free to write in the margins to clarify your answers.**

1. Personal Information

Full Name: _____ Date of birth: _____

Ethnicity: _____

Name of family member w/ Staring Spells: _____

Relationship to family member w/ Staring Spells: _____

Address (you only need to write this out once, unless it is different than the rest of the family's):

Home Phone #: (____) _____ Fax #: (____) _____

Cell/Mobile #: (____) _____ Email: _____

2. General Health

A. Are you in good health?

YES

NO

If NO, Please Describe: _____

B. What medications (if any) are you currently taking? _____

C. Have you had any serious health problems in the past?
YES NO
If so, please describe (include hospitalizations, operations): _____

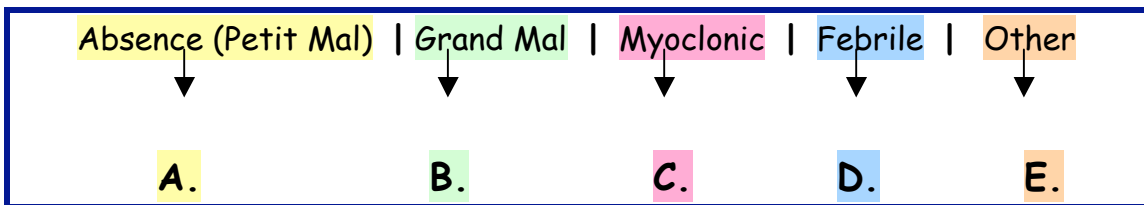
D. Have you experienced head trauma (concussion) that resulted in a loss of consciousness?
YES NO
If so, please describe (How long were you unconscious for?): _____

E. Have you had an inflammation of the brain (Meningitis/Encephalitis)?
YES NO

F. Do/Did you have severe headaches (migraine)?
YES NO

3. Epilepsy

What types of seizures have you experienced?
(Please circle all that apply, then answer the corresponding questions)



A. Absence Seizures (Petit Mal or Staring Spells) Skip if you have not had these seizures.

i. When did you have your first absence seizure? ____years ____months

Abs. SZ

Absence Seizures

ii. What did/do they look like? _____

iii. Were/are you unresponsive during these spells? YES NO

iv. Did/do they start and end abruptly? YES NO

v. What were/are the warning signs before these spells (if any)? _____

vi. Do you act normally directly after the spell? If not, how long does it take to readjust? _____

vii. How long do these spells last? _____(min/secs)

viii. What movements (eye blinking or rolling, jerking of arms, etc.) are associated with these spells (if any)?

ix. How often do they occur? _____(per day/or week)

x. When do they usually occur? Morning Evening Random

xi. Does anything make the seizures worse? (please circle all that apply)

Lack of sleep Blinking Lights Mental Concentration Other _____

B. Generalized Tonic-Clonic Seizures (Grand Mal) Skip if you have not had these seizures.

i. When did you have your first grand mal seizure? ____years ____months

ii. What did/do they look like? _____

iii. How long do the jerking movements last? _____(min/secs).

iv. Is there foaming of the mouth during these spells? YES NO

Grand Mal Sz.

Grand Mal Seizures

vii. Is there urine loss during the seizure? YES NO

v. Did you bite your tongue YES NO

v. What do you do after the seizure (sleep, have muscle sore, headache)

vi. What were/are the warning signs before these seizures (if any)?

viii. How often do they occur? _____ (per day/ or week)

ix. When do they usually occur? Morning Evening Random

x. Does anything make the seizures worse? (please circle all that apply)

Lack of sleep Blinking Lights Exercise Other _____

xi. How many grand mal seizures have you had total? _____

D. Myoclonic Jerks Skip if you have not had these seizures.

Myoclonic Jerks

i. When did you have your first myoclonic jerks? ____years ____months

ii. What did/do they look like? _____

iii. How long do the jerking movements last? _____ (min/secs).

iv. Are you conscious when these jerks occur? YES NO

v. When do they usually occur? Morning Evening Random

vi. Are they single jerks, or do multiple jerks occur in a row? _____

vii. Can they develop into a **grand mal seizure**? YES NO

E. Febrile Convulsions (Seizures associated with a high fever) Skip if you have not had these seizures.

i. When did you have your **first** febrile convulsion?
 ____years ____months

ii. When did you have your **last** febrile convulsion?
 ____years ____months

ii. What did/do they **look like**? _____

iii. **How long** do the convulsions last? _____(minutes, seconds).

iv. Were the jerking movements symmetrical (ie. did both sides of the body jerk in the same way)? _____

v. **How high** was the fever? _____(Degrees)

vi. Did you act normally directly after the spell? YES NO

vii. How many have you had? _____

I. Other Seizures --- Fill out if your seizures do not fit any of the above types

ii. What did/do they **look like**? _____

ii. When did these types of seizures begin? _____years ____months

iii. **How long** do they last? _____(min/secs).

v. What were/are the **warning signs** before these spells (if any)? _____

vi. Do you **act normally directly after** the spell? If not, how long does it take to readjust? _____

viii. **How often** do they occur? _____ (per day/ or week)

v. **When** do they usually occur? Morning Evening Random

v. Have you seen a neurologist about these spells? If so, what was the diagnosis? _____

4. Antiepileptic Medication

Currently used medications for seizures are:

<u>Brandname</u>	<u>Chemical name</u>
Zarontin	Ethosuximide
Depakote	Valproic acid
Lamictal	Lamotrigine

A. What anti-epileptic **medications** have you taken? (list in order and include dates)

Medication	From (mm/yy)	To (mm/yy)	Dose
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B. If medication was changed, why?

Didn't control seizures Side effects other seizures occurred

C. Are you/your seizures currently: (circle one)

Controlled w/ Meds Controlled w/out Meds Uncontrolled

5. Childhood/Development

A. Did your mother report any complications during pregnancy with you or with your delivery?

Pregnancy (High blood pressure, diabetes, seizures, infection, premature rupture of membranes)

YES NO

Delivery (Not on time, no normal vaginal delivery)

YES NO

If yes, please describe: _____

B. Did you have any of the following? (circle all those that apply)

Chicken Pox Measles Mumps Whooping Cough Other _____

C. What age (in years/months) did you begin speaking? _____
and walking? _____

D. Did/do you have special therapy (speech/occupational)?

YES NO

E. How did/do you do in school (A/B Student, B/C, etc.) _____

F. What level of school are you in or have you completed? (Kindergarten, Elementary School, HS, College, Masters, etc.)? _____

G. What is your Occupation? _____

H. Have you been diagnosed with learning disability?

YES NO

I. Have you been diagnosed with Hyperactivity/Attention Deficit Disorder (ADD, or ADHD)?

YES NO

