Family Study of Childhood Absence Epilepsy Questionnaire

For participants WITHOUT Epilepsy

Please fill out **one** questionnaire for **each** member of your immediate family (including those with and without epilepsy). If you have been diagnosed with epilepsy, please use our other questionnaire. Parents should fill out questionnaire for children. Please contact Dana Politis and 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

G. Have you ever had any seizures?
YES NO

If so, please describe:____

____

H. Do you ever drop things in the morning for no reason or have sudden jerks in your arms as if "hit by lightning or an electric shock")?
YES NO

If so, please describe these episodes: ___________________________

____

I. When you were young did your teachers or friends ever refer to you as "spacey" or "a daydreamer?" YES NO

If so, please describe these episodes of "spacing out": _______________

____

3. 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

J. Do/Did you get special tutoring in school? YES NO

4. Family History

A. Are there any other members of your family with seizures?

YES NO

If so, (1) what are their names, (2) how are they related to you, and (3) what types of seizures do they have? ______________________________

____

____

B. Does your family have a history of any other neurological or psychiatric disorders (ie. Migraine, learning disabilities, mental retardation, dyslexia, strokes, Alzheimer's disease, depression etc.) or malformations (i.e. Spina bifida, cleft palate etc)?

YES NO

If so, please describe. ____

____

You've reached the end of the questionnaire, Thanks for participating!