

NYU Managing Epilepsy Well (MEW) Study

Demographics and Medical History

1	Sex	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other _____	<input type="checkbox"/> Unknown <input type="checkbox"/> Not reported
2	Age	In years ____	
3	Ethnicity	<input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino	<input type="checkbox"/> Unknown <input type="checkbox"/> Not reported
4	Race	<input type="checkbox"/> Amer. Indian or Alaska Native <input type="checkbox"/> Native Hawaiian or other Pacific Islander <input type="checkbox"/> Black/African-American <input type="checkbox"/> Unknown <input type="checkbox"/> Asian <input type="checkbox"/> White <input type="checkbox"/> Not reported	
5	Education	What is the highest grade or year of school you completed? <input type="checkbox"/> Never attended school or only attended kindergarten <input type="checkbox"/> Grades 1 through 8 (Elementary) <input type="checkbox"/> Grades 9 through 11 (Some high school) <input type="checkbox"/> Grade 12 or GED (High school graduate) <input type="checkbox"/> College 1 year to 3 years (Some college or technical school) <input type="checkbox"/> College 4 years or more (College graduate)	
6	Employment (Check all that apply)	Are you currently...? <input type="checkbox"/> Employed for wages <input type="checkbox"/> A Homemaker <input type="checkbox"/> Out of work for 1 year or more <input type="checkbox"/> Unable to work <input type="checkbox"/> Self-employed <input type="checkbox"/> A Student <input type="checkbox"/> Out of work for less than 1 year <input type="checkbox"/> Retired	
7	Income	Is your annual household income from all sources— <input type="checkbox"/> Less than \$24,999 <input type="checkbox"/> \$25,000-\$49,999 <input type="checkbox"/> \$50,000 or greater How well does your income cover your needs? <input type="checkbox"/> Not very well <input type="checkbox"/> Poorly, but I get by <input type="checkbox"/> Pretty well <input type="checkbox"/> Very well	
8	Insurance Status	How do you pay for your health care? <input type="checkbox"/> Medicaid <input type="checkbox"/> Medicare <input type="checkbox"/> Public insurance other than Medicaid (VA, etc) <input type="checkbox"/> Employer provided health insurance (own plan) <input type="checkbox"/> Employer provided health insurance (dependent) <input type="checkbox"/> Individually purchased health insurance <input type="checkbox"/> No coverage	
9	Household Composition	How many children less than 18 years of age live in your household? ____ How many adults 18 and older (including yourself) live in your household? ____	
10	Relationship Status	Are you...? <input type="checkbox"/> Married <input type="checkbox"/> Never married <input type="checkbox"/> A member of an unmarried couple <input type="checkbox"/> Other <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed <input type="checkbox"/> Separated/divorced <input type="checkbox"/> Married/unmarried couple <input type="checkbox"/> Refused	

11	Country of Origin	<input type="checkbox"/> United States <input type="checkbox"/> Cuba <input type="checkbox"/> Haiti <input type="checkbox"/> Mexico <input type="checkbox"/> Dominican Republic <input type="checkbox"/> Honduras <input type="checkbox"/> China <input type="checkbox"/> Korea <input type="checkbox"/> Germany <input type="checkbox"/> India <input type="checkbox"/> Guatemala <input type="checkbox"/> Poland <input type="checkbox"/> Philippines <input type="checkbox"/> Canada <input type="checkbox"/> Ecuador <input type="checkbox"/> El Salvador <input type="checkbox"/> Jamaica <input type="checkbox"/> Peru <input type="checkbox"/> Vietnam <input type="checkbox"/> Colombia <input type="checkbox"/> Other _____
12	Number of Years in U.S.	Number of years the participant has lived in the United States _____
13	Native Language	<input type="checkbox"/> English <input type="checkbox"/> German <input type="checkbox"/> Polish <input type="checkbox"/> Spanish <input type="checkbox"/> Arabic <input type="checkbox"/> Japanese <input type="checkbox"/> Chinese <input type="checkbox"/> Russian <input type="checkbox"/> Urdu <input type="checkbox"/> Tagalog <input type="checkbox"/> French Creole <input type="checkbox"/> Farsi/Persian <input type="checkbox"/> Vietnamese <input type="checkbox"/> Italian <input type="checkbox"/> Gujarati <input type="checkbox"/> French <input type="checkbox"/> Portuguese <input type="checkbox"/> Kru, Igbo, Yoruba <input type="checkbox"/> Korean <input type="checkbox"/> Hindi <input type="checkbox"/> Other _____
14	Language Spoken in Home	<input type="checkbox"/> English <input type="checkbox"/> German <input type="checkbox"/> Polish <input type="checkbox"/> Spanish <input type="checkbox"/> Arabic <input type="checkbox"/> Japanese <input type="checkbox"/> Chinese <input type="checkbox"/> Russian <input type="checkbox"/> Urdu <input type="checkbox"/> Tagalog <input type="checkbox"/> French Creole <input type="checkbox"/> Farsi/Persian <input type="checkbox"/> Vietnamese <input type="checkbox"/> Italian <input type="checkbox"/> Gujarati <input type="checkbox"/> French <input type="checkbox"/> Portuguese <input type="checkbox"/> Kru, Igbo, Yoruba <input type="checkbox"/> Korean <input type="checkbox"/> Hindi <input type="checkbox"/> Other _____
		<p>If not English: Since you speak a language other than English at home, we are interested in your own opinion of how well you speak English. Would you say you speak English:</p> <input type="checkbox"/> Not at all <input type="checkbox"/> Poorly <input type="checkbox"/> Fairly well <input type="checkbox"/> Well <input type="checkbox"/> Very well
15	Health literacy	<p>When you read the instructions on a prescription bottle, would you say it is <input type="checkbox"/> very easy, <input type="checkbox"/> somewhat easy, <input type="checkbox"/> somewhat difficult or <input type="checkbox"/> very difficult to understand?</p> <p>When you get written information at a doctor's office, would you say it is <input type="checkbox"/> very easy, <input type="checkbox"/> somewhat easy, <input type="checkbox"/> somewhat difficult or <input type="checkbox"/> very difficult to understand?</p>
16	Health status	<p>Would you say that in general your health is—</p> <input type="checkbox"/> Excellent <input type="checkbox"/> Fair <input type="checkbox"/> Very good <input type="checkbox"/> Poor <input type="checkbox"/> Good <input type="checkbox"/> Don't know/not sure
17	Age of epilepsy diagnosis	At what age were you diagnosed with epilepsy? _____
18	Frequency of seizures	<p>Have you had a seizure in the last 30 days?</p> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused <p>If yes, how many? # of seizures in last 30 days? _____</p> <p>Have you had a seizure in the last 12 months?</p> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused <p>If yes, how many? # of seizures in last 12 months? _____</p>

19	Types of seizures	<p>I: Focal onset (seizures <u>start</u> in one part of the body)</p> <ol style="list-style-type: none"> 1. focal aware: In the past also called simple partial 2. focal with loss of awareness: In the past also called complex partial 3. Focal to bilateral tonic-clonic 4. Focal, unable to classify <p>II: Generalized onset (seizures <u>start</u> in the entire body all at once)</p> <ol style="list-style-type: none"> 1. Motor with subcategories: <ol style="list-style-type: none"> a. tonic-clonic (previously called grand mal) b. other motor: in the past also called myoclonic seizures and/or atonic seizures 2. Nonmotor (absence): in the past also called Petit mal 3. Generalized, unable to classify <p>III: Unknown onset (person with epilepsy cannot say whether this starts in one part of the body or in the entire body)</p> <ol style="list-style-type: none"> 1. Motor 2. Non-motor 3. Unclassified
20	Number of AEDs	Number of anti-epileptic drugs taken
21	AED Medication Adherence	In the past 2 weeks I have missed doses of my medicines on ____ days.
22	Psychiatric Diagnosis	<p>Are you currently being treated for depression? <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>If yes: <input type="checkbox"/> Medication <input type="checkbox"/> Counseling/therapy <input type="checkbox"/> Other _____</p> <p>Are you currently being treated for anxiety? <input type="checkbox"/> No <input type="checkbox"/> Yes: diagnosis _____</p> <p>If yes: <input type="checkbox"/> Medication <input type="checkbox"/> Counseling/therapy <input type="checkbox"/> Other _____</p> <p>Are you currently being treated for another mental health problem? <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>If yes: <input type="checkbox"/> Bipolar Disorder <input type="checkbox"/> Schizophrenia <input type="checkbox"/> ADHD <input type="checkbox"/> Other _____</p> <p>Are you currently participating in a support group or self-management program outside this study? <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>If yes, please list or describe: _____</p>

INSTRUCTIONS:

- The following question refers to your overall sleep quality for the **majority** of nights in the **past 7 days ONLY**.
- Please think about the quality of your sleep **overall**, such as how many hours of sleep you got, how easily you fell asleep, how often you woke up during the night (except to go to the bathroom), how often you woke up earlier than you had to in the morning, and how refreshing your sleep was.

1. During the **past 7 days**, how would you rate your sleep quality overall?
(Please mark only **1** box)

Terrible		Poor		Fair		Good		Excellent
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
0	1	2	3	4	5	6	7	8
								9
								10