Pediatric Epilepsy Medication Self-Management Questionnaire (Adolescent Version)

DIRECTIONS: *The following survey asks questions regarding your experience with epilepsy management, including your expectations about treatment, your beliefs about medications, and what makes it difficult to take medications.* Please complete the following items on a scale of 1 (Strongly Disagree) to 5 (Strongly Agree) for Questions 1-18 and on a scale of 1 (Never) to 5 (Always) for Questions 19-27 by placing a √ in the box that best describes you and your family.

	1 Strongly Disagree	2 Disagree	3 Neither Agree Nor Disagree	4 Agree	5 Strongly Agree
Disease and Treatment Knowledge and Expectations					
1. The doctors/nurses fully explained seizures/epilepsy (Diagnosis)					
2. I understand what side effects to look for while I am in treatment					
3. I know who to contact for questions or problems					
4. I am confident that I, in partnership with the health care team, can manage side effects if they occur					
5. I am confident that I can achieve seizure freedom					
6. I understand the risks of discontinuing my medication before I has been seizure free for 2 years					
7. My health care team listens to my concerns					
8. My health care providers are easy to contact and readily answer questions					
Adherence to Medications & Clinic Appointments					
9. I take my medicine as prescribed					
10. I have transportation available to my appointments					
11. I usually follow the medical advice and treatment plans prescribed for me					
12. I feel it is important for me to receive my treatment as directed					
13. I have no difficulty attending my follow up appointments					
14. All family members are in agreement regarding my treatment plan					
15. I receive my medication most of the time					
16. I feel it is important to assure that I am taking my medication on a daily basis					
Beliefs about Medication Efficacy					
17. Medication treatment is necessary for my medical condition					
18. The medication chosen will control my seizures					
	1 Never	**2 Seldom**	**3 Sometimes**	**4 Often**	**5 Always**
19. The medications are easy to fit into my daily schedule					
Barriers to Treatment					
20. I dislikes the taste of the medication					
21. I forget to take my medication					
22. The medication is difficult to swallow					
23. I am embarrassed to take medications in front of others (e.g., friends, family)					
24. I refuse to take my medication					
25. I have other activities that interfere with taking my medication (e.g., sports, school activities)					
26. I have run out of the medication					
27. It is difficult to get the medication from the pharmacy					

A. In the past week, I have missed _____ doses of my seizure medicine.