CIFE/DMC/ICMR No: 5/4-5/127/Neuro/2013-NCD-I

Zone No.	Ward No.	PHC No.	Cluster No.	Household ID No.	Subject No.

Follow- Up Visit 1

Subject Initial: | | | |

Date: | | | | | | | | | |

MM DD YYYY

1. Current Epilepsy medications:

Sl No	Name	Strength of unit	Frequency	No of tablets
1				
2				
3				
4				
5				
6				

No. of pills disbursed at last visit	
No of pills present in the dispenser	
No. of pills missed	

2. Any Adverse event since last visit: _____

_____

_____

3. No. of seizures occurred since last visit:_____

4. Treatment plan:

Sl No	Name	Strength of unit	Frequency	No of tablets
1				
2				
3				
4				
5				
6				

5. Number of pills given:

Sl No	Name	Strength of unit	Frequency	No of tablets
1				
2				
3				
4				
5				
6				

Questionnaires

- **Self-reported Medication-taking Scales and Item-to-total Correlation Coefficients** ☐
- **Sample items from brief medication questionnaire* Please list below all of the medications you took in the PAST WEEK. For each medication you list, Please answer each of the questions in the box below.** ☐