Medications

1. If you take any medication(s), please indicate the amount (in milligrams-mgs) that you now take and describe any side effects that you experience.

Code	Trade Name	Generic Name	Amount	Side Effects You Experience
1	Celontin	Methsuximide		
2	Depakene	Valproic Acid		
3	Depakote	Valproic Acid - Coated		
4	Diamox	Acetazolamide		
5	Dilantin	Phenytoin		
6	Felbatol	Felbamate		
7	Gabatril	Tiagabine		
8	Keppra	Levetiracetam		
9	Klonopin	Clonazepam		
10	Lamictal	Lamotrogine		
11	Luminal	Phenobarbital		
12	Mysoline	Primidone		
13	Neurontin	Gabapentin		
14	Ritalin	Methylphenidate		
15	Tegretol	Carbamazepine		
16	Topamax	Topiramate		
17	Trileptal	Okarbazepine		
18	Valium	Diazepam		
19	Zarontin	Ethosuximide		
20	Zonegran	Zonisamide		
21	Other _____			
22	Other _____			
23	Other _____			

2. Do you take your medication(s) as instructed?

___ Always ___ Usually ___ Sometimes ___ Never

3. Please check side effects which you experience from you medication(s):

_____ Poor coordination _____ Slow movement _____ Drowsiness

_____ Slow thinking _____ Double vision _____ Blurred vision

_____ Dry skin / skin rash _____ Excessive sweating _____ Dry mouth / thirst

_____ Gum problems _____ Weight gain _____ Increased heart rate

_____ Diarrhea _____ Irritability