What questions did you write down after reading the initial information about anticonvulsants and antidepressants (i.e., CNS medications)?

What side effects, if any, have you noticed with your CNS active medications?

Do you think these side effects will interfere with your participation in Sessions 4 through completion of this workbook?

What benefits do you feel you are now getting from taking your medicines, or from not taking your medicines, if you have stopped them?

Do you have any special concerns about the effects of your medicines, such as how they affect pregnancy, nutrition, alcohol, or other drugs?

Are you wondering about any other drug options, such as taking a different medicine or combination, changing dosages, or going off medication?

Do you take your medicines regularly? Yes ◯ No ◯ Sometimes ◯

Reasons I take my pills regularly:	**Reasons I do not:**
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

How do you feel about taking medicines? (Many people have conflicting feelings, so do not hesitate to express both positive and negative feelings.)

With regard to prescription drugs in particular, how do you think communication could be improved between you and your prescribing physician and seizure counselor? (Be specific about what problem areas you think need to be discussed.)

Any ideas about how you might take a more active role in your drug therapy program?

WHAT ARE YOUR PRIORITIES? PUT AN (*) BESIDE THE THREE QUESTIONS ABOVE WHICH ARE MOST IMPORTANT TO YOU. IN ADDITION TO THE CHECKLIST AT THE BEGINNING OF THIS CHAPTER, THESE WILL BE THE QUESTIONS YOU AND YOUR PHYSICIAN DISCUSS FIRST AT YOUR NEXT APPOINTMENT.