Deep brain stimulation for essential tremor

Follow-up questionnaire for patients

Personal data:
Name:
Date of birth:
Date of operation for deep brain stimulation:

Please tick all relevant boxes, if needed please give further details below

1. **Status of work situation before operation:**
   a. Full time job ☐
   b. No work ☐
   c. Partly sick leave ☐
   d. Disability benefit ☐
   e. Retired ☐

2. **Status of work situation after operation**
   a. Full time job ☐
   b. No work ☐
   c. Partly sick leave ☐
   d. Disability benefit ☐
   e. Retired ☐

3. **Status of work situation today:**
   a. Same profession as before operation ☐
   b. New profession after the operation ☐
   Describe: ______________________________

      i. Full time job ☐
      ii. No work ☐
      iii. Partly sick leave ☐
      iv. Disability benefit ☐
      v. Retired ☐

4. **Any use of medication before the operation:**
   a. No ☐
   b. Yes ☐
   Describe what type of medication you used:
   ____

5. Any use of medication after the operation:

a. No ☐
b. Yes ☐
Describe what kind of medication you used:
____

6. Any use of medication today:

a. No ☐
b. Yes ☐
Describe what kind of medication you use:
____

7. Other diseases:

a. Epilepsy ☐
b. Anxiety ☐
c. Depression ☐
d. Lung-cancer ☐
e. Other cancer ☐ Type: ____________________
f. Asthma ☐
g. Dupuytrens contraction ☐
(fixed contraction of the hand)
h. Glaucoma ☐
i. Cataract ☐
j. Heart disease ☐ Type: ____________________
k. Other ☐ Type: ____________________

8. Were you born before term?

a. No ☐
b. Yes ☐ Number of days:____________

9. Did you suffer from depression before the operation (please place a vertical mark on the line to indicate how depressed you were)?

Not depressed ______________________________________ Deeply depressed

10. Were you depressed after the operation (please place a vertical mark on the line to indicate how depressed you were)?

Not depressed ______________________________________ Deeply depressed

11. Do you feel depressed today (please place a vertical mark on the line to indicate how depressed you are)?

Not depressed ______________________________________ Deeply depressed

12. **Did you suffer from anxiety before the operation** (please place a vertical mark on the line to indicate how much you suffered from anxiety)?

No anxiety ____ Incapacitating anxiety

13. **Did you suffer from anxiety after the operation** (please place a vertical mark on the line to indicate how much you suffered from anxiety)?

No anxiety ____ Incapacitating anxiety

14. **Do you suffer from anxiety today** (please place a vertical mark on the line to indicate how much you suffer from anxiety)?

No anxiety ____ Incapacitating anxiety

15. **Side- effects of deep brain stimulation**
    a. Numbness ☐
    b. Headache ☐
    c. Abnormal taste ☐
    d. Dysarthria ☐
    e. Discomfort tongue ☐
    f. Dizziness ☐
    g. Other ☐
    Type: ____

16. **Self-reported effect of deep brain stimulation on tremor initially after first operation** (please place a vertical mark on the line to indicate the effect from deep brain stimulation on your tremor)?

No effect ____ All tremor gone

17. **Self-reported effect of deep brain stimulation on tremor today** (please place a vertical mark on the line to indicate the effect from deep brain stimulation on your tremor)?

No effect ____ All tremor gone

18. **If you have experienced reduced effect of deep brain stimulation on tremor, how long has this lasted?**
    Number of years or months: ________________

19. Are you satisfied that you have received deep brain stimulation (please place a vertical mark on the line to indicate how satisfied you are)?

Very unsatisfied ____ Very satisfied

Comments:

20. General comments: