* 1. Name

* 2. Date of Birth (XX/XX/XXXX)

Date / Time

Date

* 3. Gender

- Male
- Female
- Other (please specify)

* 4. In what ZIP code is your home located? (enter 5-digit ZIP code; for example, 00544 or 94305)

* 6. Age at Hemispherectomy

* 5. What is your annual household income?

* 6. Age at Hemispherectomy

* 7. How long has it been since the hemispherectomy?

* 8. Is your child currently seizure free?

- ◯ Yes
- ◯ No
- ◯ Other (please specify)

* 9. Is your child currently taking anti-seizure medications?

- ◯ Yes
- ◯ No
- ◯ Other (please specify)

* 10. Did your child initially have a visual field defect post surgery?

- ◯ Yes
- ◯ No
- ◯ Other (please specify)

* 11. If your child did experience a visual field defect post hemispherectomy, have there been any improvements in visual field defects over time?

- ◯ No
- ◯ Yes, a little bit of improvement (less than 25% better)
- ◯ Yes, moderate improvement (around 50% better)
- ◯ Other (please specify)
- ◯ Yes, complete improvement (100% resolution in visual field defects)
- ◯ N/A

* 12. Are there any compensatory mechanisms that have evolved to cope with post hemispherectomy visual field defects?

- ◯ Head tilted to the right
- ◯ Squinting
- ◯ Other (please specify)
- ◯ Head tilted to the left
- ◯ N/A

* 13. Are there situations or conditions that improve or negatively impact your child's visual field defect?

* 14. What was the timeline of improvement in visual field defect (if any)?

* 15. How did improvements in vision (if any) first manifest? What was the first sign that vision was improving and what particular aspect/location of the visual field defect was improving?

* 16. If your child had a decrease in visual acuity after the hemispherectomy, did the deficit improve over time?

- No
- Yes, a little improvement (less than 25% better)
- Yes, a moderate improvement (around 50% better)
- Yes, a complete resolution of visual acuity deficit (100% better)
- N/A
- Other (please specify)

* 17. If your child experienced deficits in visual acuity, are there any situations or conditions that improve or negatively impact your child' visual acuity?

* 18. Did your child experience strabismus (i.e. crossed eyes: eyes do not properly align with each other when looking at an object) after surgery?

◯ Right eye turned inwards

◯ Left eye turned outwards

◯ Left eye turned inwards

◯ Sometimes right eye turned outwards, sometimes left eye turned outwards

◯ No

◯ Sometimes right eye turned inwards, sometimes left eye turned inwards

◯ Right eye turned outwards

◯ Other (please specify)

* 19. If your child did develop strabsimus, are there any situations or conditions that improve or negatively impact your child's eye misalignment?

* 20. If your child did develop strabismus, did the deficit improve over time?

- ◯ No
- ◯ Yes, a little improvement (less than 25% better)
- ◯ Yes, a moderate improvement (around 50% better)
- ◯ Other (please specify)
- ◯ Yes, a complete resolution of strabismus (100% better)
- ◯ N/A

* 21. How has general cognitive development progressed?

- ☐ Learning Difficulties
- ☐ Reading Difficulties
- ☐ Behavioral Problems
- ☐ Other (please specify)
- ☐ Attentional Deficits
- ☐ Memory Deficits
- ☐ Psychiatric Conditions

* 22. Since the surgery, how active has your child been? (eg sports, going to the gym etc.)

- ◯ 30 min - 1 hour/day
- ◯ 3 - 4 times / week
- ◯ 1 time/ week
- ◯ 2 times/ month
- ◯ 1 time/ month
- ◯ No activity
- ◯ Other (please specify)

* 23. Has your child participated in any vision therapy or physical therapy? If so, please explain.

* 24. Please check all food options that your child eats on a routine basis

- ☐ Fruits
- ☐ Vegetables
- ☐ Grains
- ☐ Beans
- ☐ Meat
- ☐ Eggs
- ☐ Nuts/Seeds
- ☐ Processed Foods
- ☐ Chips
- ☐ Ice Cream
- ☐ Fast Food (eg McDonalds)
- ☐ Seafood
- ☐ Milk/Dairy Products
- ☐ Cookies/Cake
- ☐ Other (please specify)

DONE