Seizure diary

Date: Time that you are completing this form: ___:___

SEIZURES THAT YOU HAD SINCE 12 AM THIS MORNING:

	Seizure Type:	Seizure types:
Time: ____:____ AM / PM	_____	A: Simple partial seizure (aura, fully awake)
Time: ____:____ AM / PM	_____	B: Complex partial seizure (not fully awake)
Time: ____:____ AM / PM	_____	C: Generalized tonic clonic (grand mal)
Time: ____:____ AM / PM	_____	D: Complex partial and gen. tonic clonic
Total # of seizures: _____		E: Staring spell, no movement
		F: Brief body jerk
		G: Other _____

DID YOU TAKE YOUR MEDICATIONS TODAY?

YES SOME NONE

ARE YOU MENSTRUATING TODAY?

YES NO Not applicable

HOW MANY HRS DID YOU SLEEP LAST NIGHT?

(approximately) __ __ . __

DID YOU DRINK ALCOHOL TODAY?

YES NO MORE THAN USUAL

HOW MUCH STRESS DO YOU FEEL TODAY?
(1 = least 10 = most)

1 2 3 4 5 6 7 8 9 10

HOW MUCH ANXIETY?
(1 = least 10 = most)

1 2 3 4 5 6 7 8 9 10

DO YOU THINK YOU WILL HAVE A SEIZURE IN THE NEXT 24 HOURS?

EXTREMELY LIKELY SOMEWHAT LIKELY SOMEWHAT UNLIKELY EXTREMELY UNLIKELY

DID YOU MISS SCHOOL OR WORK BECAUSE OF A SEIZURE TODAY?

NO MISSED SCHOOL MISSED WORK

DO YOU HAVE A FEVER, COLD, OR FLU SYMPTOMS?
If yes: Please turn page over.

DID YOU SEE OR SPEAK TO YOUR DOCTOR TODAY?
If yes: Please turn page over.