

Seizure diary

Date: \_\_\_\_\_ Time that you are completing this form: \_\_\_\_:\_\_\_\_

**SEIZURES THAT YOU HAD SINCE 12 AM THIS MORNING:**

Time: ____:____ AM / PM	Seizure Type: _____	Seizure types: 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

**DID YOU TAKE YOUR MEDICATIONS TODAY?**

G: Other \_\_\_\_\_

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.