Name: _____

Seizure Diary

Patient and/or witness to complete

Date	Time of Seizure	Duration of Seizure	Time Until Full Recovery	Other Symptoms (*circle*)
/ /				**Vomiting** **Incontinence** **Fever** **Change/loss of Consiousness**
Exact description of activity and symptoms before the seizure:				☐Light-headedness ☐Sweating ☐Pallor ☐Slow Heart Rate ☐Prolonged Standing ☐Missed Meal ☐Emotive Event
Descibe your memory of the seizure:				
Parts of the body affected, and how:				
Recent medications, alcohol, drugs:				Name: Amount: Date/Time Taken:
				Name: Amount: Date/Time Taken:
Overdue medication:				Name:

Date	Time of Seizure	Duration of Seizure	Time Until Full Recovery	Other Symptoms (*circle*)
/ /				**Vomiting** **Incontinence** **Fever** **Change/loss of Consiousness**
Exact description of activity and symptoms before the seizure:				☐Light-headedness ☐Sweating ☐Pallor ☐Slow Heart Rate ☐Prolonged Standing ☐Missed Meal ☐Emotive Event
Descibe your memory of the seizure:				
Parts of the body affected, and how:				
Recent medications, alcohol, drugs:				Name: Amount: Date/Time Taken:
				Name: Amount: Date/Time Taken:
Overdue medication:				Name: