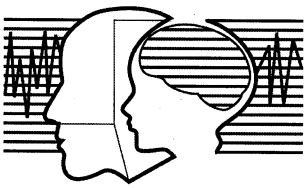

EPILEPSY INSTITUTE OF NORTH CAROLINA

SEIZURE CALENDAR

Name: _____ Month: _____ Year: _____

(Issue new calendar page(s) after each clinic visit.)

Medication prescribed and dosage: _____

	SUN _____	MON _____	TUES _____	WED _____	THUR _____	FRI _____	SAT _____
WEEK 1	☐ No seizure	☐ No seizure	☐ No seizure	☐ No seizure	☐ No seizure	☐ No seizure	☐ No seizure
WEEK 2	☐ No seizure	☐ No seizure	☐ No seizure	☐ No seizure	☐ No seizure	☐ No seizure	☐ No seizure
WEEK 3	☐ No seizure	☐ No seizure	☐ No seizure	☐ No seizure	☐ No seizure	☐ No seizure	☐ No seizure
WEEK 4	☐ No seizure	☐ No seizure	☐ No seizure	☐ No seizure	☐ No seizure	☐ No seizure	☐ No seizure
WEEK 5	☐ No seizure	☐ No seizure	☐ No seizure	☐ No seizure	☐ No seizure	☐ No seizure	☐ No seizure

Record the number of seizures per day and the type of seizure or a description of the event.

1/2014