



EPILEPSY INSTITUTE OF  
NORTH CAROLINA  
SEIZURE CALENDAR

Name: \_\_\_\_\_ Month: \_\_\_\_\_ Year: \_\_\_\_\_

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

Medication prescribed and dosage: \_\_\_\_\_

|        |                                     |                                     |                                     |                                     |                                     |                                     |                                     |
|--------|-------------------------------------|-------------------------------------|-------------------------------------|-------------------------------------|-------------------------------------|-------------------------------------|-------------------------------------|
| WEEK 1 | SUN _____                           | MON _____                           | TUES _____                          | WED _____                           | THUR _____                          | FRI _____                           | SAT _____                           |
|        | <input type="checkbox"/> No seizure | <input type="checkbox"/> No seizure | <input type="checkbox"/> No seizure | <input type="checkbox"/> No seizure | <input type="checkbox"/> No seizure | <input type="checkbox"/> No seizure | <input type="checkbox"/> No seizure |
| WEEK 2 | SUN _____                           | MON _____                           | TUES _____                          | WED _____                           | THUR _____                          | FRI _____                           | SAT _____                           |
|        | <input type="checkbox"/> No seizure | <input type="checkbox"/> No seizure | <input type="checkbox"/> No seizure | <input type="checkbox"/> No seizure | <input type="checkbox"/> No seizure | <input type="checkbox"/> No seizure | <input type="checkbox"/> No seizure |
| WEEK 3 | SUN _____                           | MON _____                           | TUES _____                          | WED _____                           | THUR _____                          | FRI _____                           | SAT _____                           |
|        | <input type="checkbox"/> No seizure | <input type="checkbox"/> No seizure | <input type="checkbox"/> No seizure | <input type="checkbox"/> No seizure | <input type="checkbox"/> No seizure | <input type="checkbox"/> No seizure | <input type="checkbox"/> No seizure |
| WEEK 4 | SUN _____                           | MON _____                           | TUES _____                          | WED _____                           | THUR _____                          | FRI _____                           | SAT _____                           |
|        | <input type="checkbox"/> No seizure | <input type="checkbox"/> No seizure | <input type="checkbox"/> No seizure | <input type="checkbox"/> No seizure | <input type="checkbox"/> No seizure | <input type="checkbox"/> No seizure | <input type="checkbox"/> No seizure |
| WEEK 5 | SUN _____                           | MON _____                           | TUES _____                          | WED _____                           | THUR _____                          | FRI _____                           | SAT _____                           |
|        | <input type="checkbox"/> No seizure | <input type="checkbox"/> No seizure | <input type="checkbox"/> No seizure | <input type="checkbox"/> No seizure | <input type="checkbox"/> No seizure | <input type="checkbox"/> No seizure | <input type="checkbox"/> No seizure |

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