

Date: _____	Time: _____	Length: ___ min. ___ sec.	Flag It
Type: <input type="checkbox"/> Simple Partial <input type="checkbox"/> Complex Partial <input type="checkbox"/> Secondary Generalized <input type="checkbox"/> Atonic <input type="checkbox"/> Tonic <input type="checkbox"/> Clonic <input type="checkbox"/> Tonic-Clonic <input type="checkbox"/> Myoclonic <input type="checkbox"/> Atypical Absence <input type="checkbox"/> Absence <input type="checkbox"/> Infantile Spasms (cluster) <input type="checkbox"/> Unknown			
Mood: <input type="checkbox"/> Good <input type="checkbox"/> Normal <input type="checkbox"/> Bad		OTC Medications _____	
Possible Triggers: <input type="checkbox"/> Changes in Medication (including late or missed) <input type="checkbox"/> Overtired or irregular sleep <input type="checkbox"/> Alcohol or drug use <input type="checkbox"/> Irregular Diet <input type="checkbox"/> Bright or flashing lights <input type="checkbox"/> Fever or overheated <input type="checkbox"/> Emotional Stress <input type="checkbox"/> Hormonal fluctuations <input type="checkbox"/> Sick – <i>Describe</i> _____ <input type="checkbox"/> Other _____ Trigger notes: _____			
Description: <input type="checkbox"/> Change in awareness <input type="checkbox"/> Loss of urine or bowel control <input type="checkbox"/> Loss of ability to communicate <input type="checkbox"/> Automatic repeated movements <input type="checkbox"/> Muscle stiffness in _____ <input type="checkbox"/> Aura <input type="checkbox"/> Muscle twitch in _____ <input type="checkbox"/> Other _____ Description notes: _____			
Post event: <input type="checkbox"/> Unable to communicate <input type="checkbox"/> Remembers event <input type="checkbox"/> Sleepy <input type="checkbox"/> Muscle weakness <input type="checkbox"/> Sleepy Post event notes: _____			
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