Teenagers & epilepsy

Keeping a Record

Date of seizure: _____ Time of seizure: _____ am/pm

Type of seizure: _____

Absence ☐ Myoclonic ☐ Atonic ☐ Tonic ☐

Tonic clonic ☐ Focal ☐ Dyscognitive ☐

Length of seizure: 0 -1minute ☐ 1-3 mins ☐ 3-5mins ☐ 5+ minutes ☐

Were you aware of your seizure? YES/ NO (circle one)

Did the seizure progress slowly / quickly? (circle one)

Did any injuries result from your seizure? YES/ NO

If yes, what were they? _____

How did you feel after the seizure?

_____

Did you feel alert / drowsy / confused after the seizure? (circle one)

Were there any triggers that could have caused the seizure? YES/ NO

If yes, what were they?_____

Notes:_____

_____

_____

_____

Source: McCaffery, M. & Beebe, A. (1999), *Pain: Clinical Manual for Nursing Practice*. St. Louis: C.V. Mosby Company.

contacting epilepsy queensland: phone 07 3435 5000 or 1300 852 853 (outside brisbane)
email services@epilepsyqueensland.com.au
mail po box 1457 coorparoo bc qld 4151