Annual Seizure Summary

Name_____ **Year**_____

Write in the appropriate box for each month and day the time seizure activity occurred and the duration of each seizure. Mark the box with an * any medicine changes, use of PRN medication, VNS adjustments, ER/Hospitalizations or injuries and describe below. Attach a Seizure Activity Checklist for each seizure. Bring this form to all neurology appointments.

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Total												

Include date, time and signature for each entry._____