NAME:

DOB:

LMP (FEMALE)

MEDICATIONS:

DATE	**TIME**	**LENGTH** ______min ______sec.
TRIGGERS	**DESCRIPTION**	**POST EVENT**
☐ Overtired ☐ Bright lights ☐ Alcohol ☐ Drug Use ☐ Fever/Overheated ☐ Illness ☐ Irregular Diet ☐ Emotional Stress ☐ Other_________	☐ Change in awareness ☐ Loss of ability to communicate ☐ Automatic repeated movements ☐ Loss of urine or bowel control ☐ Tongue biting ☐ Muscle stiffness in _______________ ☐ Muscle twitch in _______________ ☐ Warning/Feeling Before: __________ Description:	☐ Unable to communicate ☐ Confusion ☐ Remembers event ☐ Sleepy ☐ Muscle Weakness ☐ Other _____________ Description:

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