
SEIZURE DIARY

A seizure diary is a good way of keeping track of your focal seizures. It can help you and your health care provider understand how severe the seizures are, how long they last, possible triggers to consider, and more.

Once you're done filling out this diary, email it to a member of your health care team. He or she can use it to determine how well you're doing and what, if anything, needs to happen next in your treatment plan.

TRACKING YOUR SEIZURE

TRACKING AND MONITORING

After each seizure you have, try to answer the questions below and on the next page.

Once you've completed the entire diary, email it to your health care provider so he or she can better understand your focal seizures.

DATE:

TIME:

How long did your seizure last?

How severe was your seizure?

On a scale of 1 to 10, with 1 being the least severe and 10 being the most severe, select the number that best captures the severity of your seizure:

1 **2** **3** **4** **5** **6** **7** **8** **9** **10**



LEAST SEVERE

MOST SEVERE

BEFORE YOUR SEIZURE

What activities were you engaged in?

What medications were you taking—and at what dose?

Did you take these medications as prescribed? **YES** **NO**

Did you experience any warning signs before your seizure? **YES** **NO**

(Questions continue on the next page.)

You are encouraged to report negative side effects of prescription drugs to the FDA. Visit www.fda.gov/medwatch or call 1-800-FDA-1088.

The information and advice published or made available through this diary are for informational purposes only and are not a substitute for professional, medical, or legal advice or services. Always talk to your doctor or health care provider before making any medical decisions.

TRACKING YOUR SEIZURE (CONT'D)

DURING YOUR SEIZURE

Did you remain aware of events going on around you? **YES** **NO**

Were you able to communicate? **YES** **NO**

Which side of your body was affected? **RIGHT** **LEFT** **BOTH SIDES**

Did you experience body movement that was repetitive or automatic? **YES** **NO**

Did you experience muscle stiffness? **YES** **NO**

If so, where? **ARM** **LEG** **ENTIRE BODY**

Did you experience muscle twitching? **YES** **NO**

If so, where? **ARM** **LEG** **ENTIRE BODY**

Other seizure symptoms your doctor should know (tongue biting, wandering, fall, injury, etc.):

Other information your doctor should know (stress, changes in medication, side effects, sudden mood swings, etc.):

NOTES

You are encouraged to report negative side effects of prescription drugs to the FDA. Visit www.fda.gov/medwatch or call 1-800-FDA-1088.

The information and advice published or made available through this diary are for informational purposes only and are not a substitute for professional, medical, or legal advice or services. Always talk to your doctor or health care provider before making any medical decisions.

TRACKING YOUR SEIZURE

TRACKING AND MONITORING

After each seizure you have, try to answer the questions below and on the next page.

Once you've completed the entire diary, email it to your health care provider so he or she can better understand your focal seizures.

DATE: TIME:

How long did your seizure last?

How severe was your seizure?

On a scale of 1 to 10, with 1 being the least severe and 10 being the most severe, select the number that best captures the severity of your seizure:

1 **2** **3** **4** **5** **6** **7** **8** **9** **10**

LEAST SEVERE

MOST SEVERE

BEFORE YOUR SEIZURE

What activities were you engaged in?

What medications were you taking—and at what dose?

Did you take these medications as prescribed? YES NO

Did you experience any warning signs before your seizure? YES NO

(Questions continue on the next page.)

You are encouraged to report negative side effects of prescription drugs to the FDA. Visit www.fda.gov/medwatch or call 1-800-FDA-1088.

The information and advice published or made available through this diary are for informational purposes only and are not a substitute for professional, medical, or legal advice or services. Always talk to your doctor or health care provider before making any medical decisions.

TRACKING YOUR SEIZURE (CONT'D)

DURING YOUR SEIZURE

Did you remain aware of events going on around you? YES NO

Were you able to communicate? YES NO

Which side of your body was affected? RIGHT LEFT BOTH SIDES

Did you experience body movement that was repetitive or automatic? YES NO

Did you experience muscle stiffness? YES NO

If so, where? ARM LEG ENTIRE BODY

Did you experience muscle twitching? YES NO

If so, where? ARM LEG ENTIRE BODY

Other seizure symptoms your doctor should know (tongue biting, wandering, fall, injury, etc.):

Other information your doctor should know (stress, changes in medication, side effects, sudden mood swings, etc.):

NOTES

TRACKING YOUR SEIZURE

TRACKING AND MONITORING

After each seizure you have, try to answer the questions below and on the next page.

Once you've completed the entire diary, email it to your health care provider so he or she can better understand your focal seizures.

DATE: TIME:

How long did your seizure last?

How severe was your seizure?

On a scale of 1 to 10, with 1 being the least severe and 10 being the most severe, select the number that best captures the severity of your seizure:

1 **2** **3** **4** **5** **6** **7** **8** **9** **10**

LEAST SEVERE

MOST SEVERE

BEFORE YOUR SEIZURE

What activities were you engaged in?

What medications were you taking—and at what dose?

Did you take these medications as prescribed? YES NO

Did you experience any warning signs before your seizure? YES NO

(Questions continue on the next page.)

You are encouraged to report negative side effects of prescription drugs to the FDA. Visit www.fda.gov/medwatch or call 1-800-FDA-1088.

The information and advice published or made available through this diary are for informational purposes only and are not a substitute for professional, medical, or legal advice or services. Always talk to your doctor or health care provider before making any medical decisions.

TRACKING YOUR SEIZURE (CONT'D)

DURING YOUR SEIZURE

Did you remain aware of events going on around you? YES NO

Were you able to communicate? YES NO

Which side of your body was affected? RIGHT LEFT BOTH SIDES

Did you experience body movement that was repetitive or automatic? YES NO

Did you experience muscle stiffness? YES NO

If so, where? ARM LEG ENTIRE BODY

Did you experience muscle twitching? YES NO

If so, where? ARM LEG ENTIRE BODY

Other seizure symptoms your doctor should know (tongue biting, wandering, fall, injury, etc.):

Other information your doctor should know (stress, changes in medication, side effects, sudden mood swings, etc.):

NOTES

TRACKING YOUR SEIZURE

TRACKING AND MONITORING

After each seizure you have, try to answer the questions below and on the next page.

Once you've completed the entire diary, email it to your health care provider so he or she can better understand your focal seizures.

DATE: TIME:

How long did your seizure last?

How severe was your seizure?

On a scale of 1 to 10, with 1 being the least severe and 10 being the most severe, select the number that best captures the severity of your seizure:

1 **2** **3** **4** **5** **6** **7** **8** **9** **10**

LEAST SEVERE

MOST SEVERE

BEFORE YOUR SEIZURE

What activities were you engaged in?

What medications were you taking—and at what dose?

Did you take these medications as prescribed? YES NO

Did you experience any warning signs before your seizure? YES NO

(Questions continue on the next page.)

You are encouraged to report negative side effects of prescription drugs to the FDA. Visit www.fda.gov/medwatch or call 1-800-FDA-1088.

The information and advice published or made available through this diary are for informational purposes only and are not a substitute for professional, medical, or legal advice or services. Always talk to your doctor or health care provider before making any medical decisions.

TRACKING YOUR SEIZURE (CONT'D)

DURING YOUR SEIZURE

Did you remain aware of events going on around you? YES NO

Were you able to communicate? YES NO

Which side of your body was affected? RIGHT LEFT BOTH SIDES

Did you experience body movement that was repetitive or automatic? YES NO

Did you experience muscle stiffness? YES NO

If so, where? ARM LEG ENTIRE BODY

Did you experience muscle twitching? YES NO

If so, where? ARM LEG ENTIRE BODY

Other seizure symptoms your doctor should know (tongue biting, wandering, fall, injury, etc.):

Other information your doctor should know (stress, changes in medication, side effects, sudden mood swings, etc.):

NOTES

TRACKING YOUR SEIZURE

TRACKING AND MONITORING

After each seizure you have, try to answer the questions below and on the next page.

Once you've completed the entire diary, email it to your health care provider so he or she can better understand your focal seizures.

DATE: TIME:

How long did your seizure last?

How severe was your seizure?

On a scale of 1 to 10, with 1 being the least severe and 10 being the most severe, select the number that best captures the severity of your seizure:

1 **2** **3** **4** **5** **6** **7** **8** **9** **10**

LEAST SEVERE

MOST SEVERE

BEFORE YOUR SEIZURE

What activities were you engaged in?

What medications were you taking—and at what dose?

Did you take these medications as prescribed? YES NO

Did you experience any warning signs before your seizure? YES NO

(Questions continue on the next page.)

You are encouraged to report negative side effects of prescription drugs to the FDA. Visit www.fda.gov/medwatch or call 1-800-FDA-1088.

The information and advice published or made available through this diary are for informational purposes only and are not a substitute for professional, medical, or legal advice or services. Always talk to your doctor or health care provider before making any medical decisions.

TRACKING YOUR SEIZURE (CONT'D)

DURING YOUR SEIZURE

Did you remain aware of events going on around you? YES NO

Were you able to communicate? YES NO

Which side of your body was affected? RIGHT LEFT BOTH SIDES

Did you experience body movement that was repetitive or automatic? YES NO

Did you experience muscle stiffness? YES NO

If so, where? ARM LEG ENTIRE BODY

Did you experience muscle twitching? YES NO

If so, where? ARM LEG ENTIRE BODY

Other seizure symptoms your doctor should know (tongue biting, wandering, fall, injury, etc.):

Other information your doctor should know (stress, changes in medication, side effects, sudden mood swings, etc.):

NOTES

TRACKING YOUR SEIZURE

TRACKING AND MONITORING

After each seizure you have, try to answer the questions below and on the next page.

Once you've completed the entire diary, email it to your health care provider so he or she can better understand your focal seizures.

DATE: TIME:

How long did your seizure last?

How severe was your seizure?

On a scale of 1 to 10, with 1 being the least severe and 10 being the most severe, select the number that best captures the severity of your seizure:

1 **2** **3** **4** **5** **6** **7** **8** **9** **10**

LEAST SEVERE

MOST SEVERE

BEFORE YOUR SEIZURE

What activities were you engaged in?

What medications were you taking—and at what dose?

Did you take these medications as prescribed? YES NO

Did you experience any warning signs before your seizure? YES NO

(Questions continue on the next page.)

You are encouraged to report negative side effects of prescription drugs to the FDA. Visit www.fda.gov/medwatch or call 1-800-FDA-1088.

The information and advice published or made available through this diary are for informational purposes only and are not a substitute for professional, medical, or legal advice or services. Always talk to your doctor or health care provider before making any medical decisions.

TRACKING YOUR SEIZURE (CONT'D)

DURING YOUR SEIZURE

Did you remain aware of events going on around you? YES NO

Were you able to communicate? YES NO

Which side of your body was affected? RIGHT LEFT BOTH SIDES

Did you experience body movement that was repetitive or automatic? YES NO

Did you experience muscle stiffness? YES NO

If so, where? ARM LEG ENTIRE BODY

Did you experience muscle twitching? YES NO

If so, where? ARM LEG ENTIRE BODY

Other seizure symptoms your doctor should know (tongue biting, wandering, fall, injury, etc.):

Other information your doctor should know (stress, changes in medication, side effects, sudden mood swings, etc.):

NOTES

TRACKING YOUR SEIZURE

TRACKING AND MONITORING

After each seizure you have, try to answer the questions below and on the next page.

Once you've completed the entire diary, email it to your health care provider so he or she can better understand your focal seizures.

DATE: TIME:

How long did your seizure last?

How severe was your seizure?

On a scale of 1 to 10, with 1 being the least severe and 10 being the most severe, select the number that best captures the severity of your seizure:

1 **2** **3** **4** **5** **6** **7** **8** **9** **10**

LEAST SEVERE

MOST SEVERE

BEFORE YOUR SEIZURE

What activities were you engaged in?

What medications were you taking—and at what dose?

Did you take these medications as prescribed? YES NO

Did you experience any warning signs before your seizure? YES NO

(Questions continue on the next page.)

You are encouraged to report negative side effects of prescription drugs to the FDA. Visit www.fda.gov/medwatch or call 1-800-FDA-1088.

The information and advice published or made available through this diary are for informational purposes only and are not a substitute for professional, medical, or legal advice or services. Always talk to your doctor or health care provider before making any medical decisions.

TRACKING YOUR SEIZURE (CONT'D)

DURING YOUR SEIZURE

Did you remain aware of events going on around you? **YES** **NO**

Were you able to communicate? **YES** **NO**

Which side of your body was affected? **RIGHT** **LEFT** **BOTH SIDES**

Did you experience body movement that was repetitive or automatic? **YES** **NO**

Did you experience muscle stiffness? **YES** **NO**

If so, where? **ARM** **LEG** **ENTIRE BODY**

Did you experience muscle twitching? **YES** **NO**

If so, where? **ARM** **LEG** **ENTIRE BODY**

Other seizure symptoms your doctor should know (tongue biting, wandering, fall, injury, etc.):

Other information your doctor should know (stress, changes in medication, side effects, sudden mood swings, etc.):

NOTES

Sumitomo Pharma

APTIO[®]M is a registered trademark of [Bial](#), used under license.  is a trademark of Sumitomo Pharma Co., Ltd., used under license. SUMITOMO PHARMA is a trademark of Sumitomo Pharma Co., Ltd., used under license. SUMITOMO is a registered trademark of Sumitomo Chemical Co., Ltd., used under license. Sumitomo Pharma America, Inc. is a U.S. subsidiary of Sumitomo Pharma Co. Ltd.
©2023 Sumitomo Pharma America, Inc. All rights reserved.
09/23 APT-US-00118-23

You are encouraged to report negative side effects of prescription drugs to the FDA. Visit www.fda.gov/medwatch or call 1-800-FDA-1088.

The information and advice published or made available through this diary are for informational purposes only and are not a substitute for professional, medical, or legal advice or services. Always talk to your doctor or health care provider before making any medical decisions.