



SEIZURE/EPILEPSY QUESTIONNAIRE (Complete all questions)

Name of primary applicant: _____ ID/SSN: _____

Name of person treated/relationship to applicant: _____

1. Please indicate type of seizure: _____ Grand Mal _____ Petit Mal _____ Other (specify)
 _____ Febrile _____ Myoclonic _____ Jacksonian _____ Partial

Details of symptoms: _____

2. Date of first seizure: _____ Frequency of seizures: _____

Date of last seizure: _____

3. Details of treatment: _____

4. Have you ever been hospitalized because of seizures? ___ Yes ___ No. If yes, provide complete details regarding dates of hospitalization(s), duration of stay(s) and treatment(s) received:

5. Are you taking medication(s) for this condition? ___ Yes ___ No.

Name of Medication: _____ **Dosage:** _____ **Frequency (ie., daily, as needed)** _____

If no, did your doctor recommend discontinuation? ___ Yes ___ No. Date discontinued: _____

6. Name and address of treating physician: _____

Date last seen? _____

7. Any loss of time at work or restricted activities: _____

8. Results and dates of any special test/studies:

Dates

Test / Studies results

9. Any other comments? _____

All of the above statements are true, complete and correctly recorded to the best of my knowledge. I understand that the insurer will rely on these statements when determining eligibility.

Signature of person treated (or parent / guardian if under 18)

Date

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