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