



SEIZURE DISORDER QUESTIONNAIRE

Name _____ Date of birth _____

Residence address _____

1. Have you ever had seizures or fainting spells, if so what type (Petit Mal, Grand Mal, etc.) and the dates they occurred?

2. What did your doctor tell you was the problem or cause (i.e., Epilepsy, Tetany)?

3a. How often do you have attacks (weekly, monthly, yearly, etc.)?	3b. On what occasions?	3c. During the day or night?

4. How long do the attacks last?

5. When was the last attack? ____ / ____ / ____

6a. What kind of treatment have you received (medical/surgical) Give particulars and dates.	6b. What medicines are you taking?	6c. Have you been hospitalized for seizures? Include dates and hospital names.

7. Do you have any other diseases, symptoms or complaints? If so give particulars.

8. Do you receive or have you ever received any kind of disability compensation Yes No? If "Yes", what was the cause?

9. Name and address of your attending physician.

I represent that all statements and answers to the questions are complete and true to the best on my knowledge and belief.

Signature of Proposed Insured _____ Date ____ / ____ / ____

Witness _____ Date ____ / ____ / ____