

# Seizure/Epilepsy Questionnaire

Addendum to Application for Health Insurance

(Complete all questions. Please contact your physician for assistance if necessary.)

Name of primary applicant: \_\_\_\_\_ ID/SSN: \_\_\_\_\_

Form No. \_\_\_\_\_

Name of person treated: \_\_\_\_\_ Relationship to applicant: \_\_\_\_\_

1. Please indicate type of seizure:

- Grand mal       Petit mal       Febrile       Partial  
 Myoclonic       Jacksonian       Other \_\_\_\_\_

2. Describe symptoms: \_\_\_\_\_  
\_\_\_\_\_

3. Date of first seizure: \_\_\_\_\_ Frequency of seizures: \_\_\_\_\_ Date of last seizure: \_\_\_\_\_

4. Describe treatment of seizures: \_\_\_\_\_  
\_\_\_\_\_

5. Have you had loss of time at work or restricted activities due to seizures?  Yes  No If yes, please give details: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

6. Have you ever gone to the hospital because of seizures?  Yes  No If yes, provide name and address of hospital, date of admission and discharge and treatment received: \_\_\_\_\_  
\_\_\_\_\_

7. Are you taking medication(s) for this condition?  Yes  No If yes, please list:

Name of medication	Amount taken per day	How often per day
_____	_____	_____
_____	_____	_____

Have you taken medication for this condition that the physician has discontinued?  Yes  No If yes, please indicate type of medication and date discontinued: \_\_\_\_\_  
\_\_\_\_\_

8. Name and address of treating physician: \_\_\_\_\_  
\_\_\_\_\_  
Date of last appointment with physician: \_\_\_\_\_

9. Have you ever had any of the following testing done?  EEG  CT scan  MRI  Other: \_\_\_\_\_  
Please indicate dates of testing and test results: \_\_\_\_\_  
\_\_\_\_\_

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

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

\_\_\_\_\_  
Date