Epilepsy/Seizure Disorder

Questionnaire

Please answer all questions applicable to the client’s medical history.

Producer Name__________________ Phone____________________ Date__________________

Client Name__________________ Date of Birth__________________ Male □ Female □

Face Amount__________________ Max Premium $_______________/yr. □ Term □ Permanent

Has the client ever used any form of tobacco (cigarettes, cigars, pipe, snuff, etc.)? □ Yes □ No
Frequency__________________ Date of last use__________________ Type__________________

Date of diagnosis__________________ Date of last episode__________________

Type of epilepsy or seizure diagnosed
□ Generalized seizures □ Sleep epilepsy □ Traumatic epilepsy □ Television epilepsy □ “Single Fit”

What terms have been used to describe the character of the epileptic or seizure attack(s) (select all that apply)
□ Grand mal □ Petit mal □ Partial seizure-complex □ Partial seizure-simple
Focal seizures: □ Motor □ Sensory □ Temporal lobe
Centrencephalic seizures: □ Absence attacks □ Myoclonus seizures □ Atonic spells
□ Other__________________

Frequency of the epileptic episodes

<table>
<thead>
<tr>
<th>Name of Medication (prescription or otherwise)</th>
<th>Dates Used</th>
<th>Quantity Taken</th>
<th>Frequency Taken</th>
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Has any surgical procedure been recommended/done to treat the condition? □ Yes □ No If yes, date of surgery__________________

□ Hospitalization (due to condition) □ ER visits (due to condition) If yes, date(s)__________________

Does the client drive a motor vehicle? □ Yes □ No Occupation__________________

Does the client engage in any hazardous activities? □ Yes □ No If yes, describe__________________

List any other major health problems the client has: