SEIZURES QUESTIONNAIRE

Reset Form

Name	Date of Birth (dd/mmm/yy)	Application #

1. What type of seizures have you had?

◯ Grand mal ◯ Petit Mal ◯ Generalized ◯ Myoclonic ◯ Tonic-clonic ◯ Atonic ◯ Other

Do you experience any:

◯ Aura or warning - If yes, please give details.

◯ Loss of consciousness - If yes, how long?

◯ Attacks at night only?

2. When was your first episode? | When was your last episode?

How many episodes have you had in the past 24 months?

Are there any known triggers for your episodes?

Name address & phone number of medical adivsor(s) consulted:

Details of any medication taken:

Type	Dose	Frequency

◯ Still taking medication | Date medication was stopped (dd/mmm/yy)

Date & results of last head x-ray (dd/mmm/yy): ◯ never had one

Date & results of last head CT scan or MRI (dd/mmm/yy): ◯ never had one

Date & results of last EEG (dd/mmm/yy): ◯ never had one

I hereby declare that the above answers are complete and true, and agree that they shall form part of my application for the policy requested.

Signature of Applicant	Signature of Witness	Date (dd/mmm/yy)
X	X	

Empire Life™