



Epilepsy/Seizures Questionnaire

Insurance Designers of Central Texas, LLC

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Phone 512-257-9700 FAX 512-257-9701

Today's Date:

Agent:

Full Name:

Male or Female?

Height and weight:

Date of Birth:

1. Month and year diagnosed:_____ Age at diagnosis:_____

2. What type of seizures do you have?

(Please call your doctor and ask for the specific diagnosis if you are not sure).

- | | |
|------------------------------------|---|
| <input type="checkbox"/> Grand Mal | (unconsciousness, convulsions, muscle rigidity) |
| <input type="checkbox"/> Absence | (brief loss of consciousness) |
| <input type="checkbox"/> Myoclonic | (sporadic/isolated, jerking movements) |
| <input type="checkbox"/> Clonic | (repetitive, jerking movements) |
| <input type="checkbox"/> Tonic | (muscle stiffness, rigidity) |
| <input type="checkbox"/> Atonic | (loss of muscle tone) |

3. Indicate the number or frequency of episodes:

4. Date of last episode:

5. What medications do you take, reason, dosage and how often?

6. What is your occupation?

7. When was your most recent MRI? If you have a copy of it, please attach it to this questionnaire, as it will contain information that will help us get the most accurate quote.

8. How often do you see your doctor?

Every six months Every 12 months Other (explain):

9. Has your weight remained stable in the past year? Yes No

If no: Lost _____ pounds OR Gained _____ pounds

10. Please indicate type of tobacco EVER used:

Type:	Amount per (circle frequency):	Date last used:	Still use?
<input type="checkbox"/> Smokeless	<input type="checkbox"/> daily/monthly/yearly	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Cigarettes	<input type="checkbox"/> per day/month/year	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Cigar	<input type="checkbox"/> per day/month/year	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Patch/Gum	<input type="checkbox"/> per day/month/year	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No