Epilepsy/Seizure Questionnaire

Title | Surname

Given name(s)

Date of birth

/ /

1 Please advise the type of epilepsy or seizures?

- ☐ Tonic-clonic seizures (Grand mal seizures)
- ☐ Absence seizures (Petit mal seizures)
- ☐ Atonic seizures
- ☐ Tonic seizures
- ☐ Myoclonic seizures
- ☐ Other, please specify

2 When did you have your first episode of epilepsy, and how old were you?

3 When was your most recent episode of epilepsy?

4 How many episodes have you had in the past 2 years?

5 Please advise the names and addresses of Doctors consulted and the date first and last consulted.

Name

Address

State | Postcode

Date first consulted / /

Date last consulted / /

Question 5 continued …

Name

Address

State | Postcode

Date first consulted / /

Date last consulted / /

6 Have you had a CT scan, EEG or other tests or investigations?

- ☐ No — ***Go to next question***
- ☐ Yes

Please provide details, including dates and results

7 What treatment have you been given?

Treatment type	Dosage

8 Are you still taking treatment?

- ☐ No — When did treatment cease? / /
- ☐ Yes

9 Have you lost time from work?

No ☐ ***Go to next question***

Yes ☐

Please provide details, including dates

10 Are you limited in your ability to work or your activities of daily living as a result of this condition?

No ☐ ***Go to Declaration***

Yes ☐

Please provide details

DECLARATION

The answers to the questions above are true and complete and this supplementary questionnaire forms part of my application for insurance.

Signature

X ..... Date / /

Please return this completed form to:

Smartsave
PO Box 1282
Albury
NSW 2640