

# Epilepsy questionnaire

(to be completed by the medical attendant)

## Instructions

Please complete this form in **CAPITAL** letters. All questions must be answered accurately with full disclosure of all relevant information. If there is insufficient space for any answer please continue on a separate piece of paper and attach to this questionnaire.

## 1 Personal details

Policy number (if known)

### Full name of life to be insured

Title  Mr  Mrs  Miss  Ms  Dr  Other (please give details)

Family name

Forename(s)

Date of birth

D	D	M	M	Y	Y	Y	Y
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## 2 Supplementary questions

### 2.1 Diagnosis

2.1.1. Please state the date the epilepsy was initially diagnosed

D	D	M	M	Y	Y	Y	Y
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2.1.2. What is/was the cause of the epilepsy?

2.1.3. Are attacks precipitated by any particular factor, such as alcohol, stress, etc.

Yes  No

If 'Yes', please provide details

### 2.2 Type of epilepsy

Please provide details of the type of epilepsy or nature of the attacks by ticking the appropriate description(s)

#### Petit-mal type:

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Absence epilepsy    | <input type="checkbox"/> Benign epilepsy of childhood | <input type="checkbox"/> Febrile seizures            |
| <input type="checkbox"/> Petit-mal absence   | <input type="checkbox"/> Jacksonian seizure           | <input type="checkbox"/> Juvenile myoclonic epilepsy |
| <input type="checkbox"/> Neonatal convulsion | <input type="checkbox"/> Pykno-epilepsy               | <input type="checkbox"/> Rolandic epilepsy           |
| <input type="checkbox"/> Versive seizure     |   |  |

#### Grand-mal type:

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Astatic seizure      | <input type="checkbox"/> Psychomotor attack | <input type="checkbox"/> Generalised seizure   |
| <input type="checkbox"/> Grand-mal seizure    | <input type="checkbox"/> Clonic seizure     | <input type="checkbox"/> Complex focal seizure |
| <input type="checkbox"/> Tonic-clonic seizure | <input type="checkbox"/> Tonic seizure      |  |

## 2.3 Type of investigation

Has your patient undergone any investigations, such as EEG, CT or MRI scan?

Yes  No

If 'Yes', please provide details including dates of investigation(s) and results

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## 2.4 Frequency and severity of seizures

2.4.1. Please state the number of attacks your patient has had in each of the last three years by ticking the appropriate options below

	None	1-3	4-6	7-10	11+
1 year ago	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2 years ago	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3 years ago	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

2.4.2. What was the date of your patient's last attack?

2.4.3. Has your patient lost consciousness in an attack?

Yes  No

If 'Yes', please state the date this last occurred

2.4.4. Has your patient ever been hospitalized due to their epilepsy?

Yes  No

If 'Yes', please advise details and dates

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2.4.5. Have there been any episodes of status epilepticus?

Yes  No

If 'Yes', please advise details and dates

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## 2.5 Type of treatment

Please provide details and dates of any treatment(s) you are currently prescribing, or have prescribed in the past. Include names of medication (i.e. Dilantin, Tegretol, etc.), dosage, how often it is taken, and how long your patient has been using it.

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## 2.6 Monitoring the condition

How often does your patient visit you to have his/her condition monitored?

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## 2.7. Driving, work and other activities

2.7.1 Does your patient currently hold a driving licence?

Yes  No

2.7.2. Has your patient ever been refused a driving licence or had this withdrawn due to epilepsy?

Yes  No

2.7.3. Has your patient at any time been off work with his/her condition?

Yes  No

If 'Yes', please state date(s) and duration.

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2.7.4. Has your patient had to restrict his/her activities in any way due to their condition?

Yes  No

If 'Yes', please give details

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## 2.9 Additional information

Please provide us with any additional information about your patient's condition that will help us assess his/her proposal. In particular, whether there have been any associated learning difficulties.

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## 3 Your details

Signature of medical attendant

Date

D	D	M	M	Y	Y	Y	Y
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Name of medical attendant (in capital letters)

Qualifications

Address for correspondence (in capital letters)

Telephone number

Fax number

Email address

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