CPS INSURANCE SERVICES

SEIZURE DISORDER QUESTIONNAIRE

Name_____ Date of birth_____

Residence address_____

1.Have you ever had seizures or fainting spells, if so what type (Petit Mal, Grand Mal, etc.) and the dates they occurred?

_____

_____

2. What did your doctor tell you was the problem or cause (i.e., Epilepsy, Tetany)?

_____

_____

3a. How often do you have attacks (weekly, monthly, yearly, etc.)?	3b. On what occasions?	3c. During the day or night?

4. How long do the attacks last?

_____

5. When was the last attack? _____/_____/_____

6a. What kind of treatment have you received (medical/surgical) Give particulars and dates.	6b. What medicines are you taking?	6c. Have you been hospitalized for seizures? Include dates and hospital names.

7. Do you have any other diseases, symptoms or complaints? If so give particulars.

_____

8. Do you receive or have you ever received any kind of disability compensation ☐ Yes ☐ No? If "Yes", what was the cause?

_____

9. Name and address of your attending physician.

_____

I represent that all statements and answers to the questions are complete and true to the best on my knowledge and belief.

Signature of Proposed Insured_____ Date_____/_____/_____

Witness_____ Date_____/_____/_____

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NATIONAL ASSOCIATION OF INDEPENDENT LIFE BROKERAGE AGENCIES