

# Epilepsy Or Seizure Questionnaire

**Claims Administrator:**  
 Consociate • Dansig  
 Attn: Underwriting  
 111 E. Decatur Street, P.O. Box 1068  
 Decatur, IL 62525  
 Phone: (888) 242-4357  
 Fax: (217) 451-9088

Group name: \_\_\_\_\_

Employee name: \_\_\_\_\_

Dependent name (if condition is for dependent) \_\_\_\_\_

Age: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

1. Type of seizures, i.e. Grand mal, petit, other? \_\_\_\_\_

2. Date of first seizure \_\_\_\_\_ Date of last seizure \_\_\_\_\_

3. Frequency and length of seizures \_\_\_\_\_

\_\_\_\_\_

4. Any cause for seizures ever given, i.e. injury, alcohol/drug abuse, related to infection, Genetic disorder or brain tumor/aneurysm, etc.? \_\_\_\_\_

\_\_\_\_\_

| Medication name | Dosage | Frequency | Current?<br>Yes or No | Date stopped |
|-----------------|--------|-----------|-----------------------|--------------|
| _____           | _____  | _____     | Yes or No             | _____        |
| _____           | _____  | _____     | Yes or No             | _____        |
| _____           | _____  | _____     | Yes or No             | _____        |
| _____           | _____  | _____     | Yes or No             | _____        |

6. Any driving restrictions or other limitations as a result of the seizures? Yes or No  
 If yes, please specify. \_\_\_\_\_

Please be advised that you may be required to submit medical records.

Employee signature: \_\_\_\_\_ Date: \_\_\_\_\_

