# 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

### 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

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:**

- ☐ Absence epilepsy
- ☐ Benign epilepsy of childhood
- ☐ Febrile seizures
- ☐ Petit-mal absence
- ☐ Jacksonian seizure
- ☐ Juvenile myoconic epilepsy
- ☐ Neonatal convulsion
- ☐ Pykno-epilepsy
- ☐ Rolandic epilepsy
- ☐ Versive seizure

**Grand-mal type:**

- ☐ Astatic seizure
- ☐ Psychomotor attack
- ☐ Generalised seizure
- ☐ Grand-mal seizure
- ☐ Clonic seizure
- ☐ Complex focal seizure
- ☐ Tonic-clonic seizure
- ☐ 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

## 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 | ☐ | ☐ | ☐ | ☐ | ☐ |
| 2 years ago | ☐ | ☐ | ☐ | ☐ | ☐ |
| 3 years ago | ☐ | ☐ | ☐ | ☐ | ☐ |

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

2.4.3. Has your patient lost consciousness in an attack? ☐ Yes ☐ No

If 'Yes', please state the date this last occurred D D M M Y Y Y Y

2.4.4. Has your patient ever been hospitalized due to their epilepsy? ☐ Yes ☐ No

If 'Yes', please advise details and dates

2.4.5. Have there been any episodes of status epilepticus? ☐ Yes ☐ No

If 'Yes', please advise details and dates

## 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.

## 2.6 Monitoring the condition

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

## 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.

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

## 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.

# 3 Your details

Signature of medical attendant

Date D D M M Y Y Y Y

Name of medical attendant (in capital letters)

Qualifications

Address for correspondence (in capital letters)

Telephone number

Fax number

Email address





ZURICH