Anthem
P.O. Box 173334
Denver, CO 80217-9411

SEIZURE/EPILEPSY QUESTIONNAIRE

Please answer all questions pertaining to the person for which the condition applies. If you need assistance in completing this form, please contact your physician. If you need more space, please turn this sheet over and continue.

Name of primary applicant:______________________________ ID/SSN:_____________________________________

Name of person treated/relationship to applicant: ____

1. Please indicate type of seizure: _____Grand Mal _____Petit Mal _____Febrile _____Myoclonic
   _______ Jacksonian ______ Partial _____other (specify)_____________________________________

   Details of symptoms:____

2. Date of first seizure: ____________ Frequency of seizures:_________Date of last seizure:____________

3. Details of treatment: ____

   ____

4. Have you ever been hospitalized because of seizures? ___yes ___no. If yes, provide complete details regarding dates of hospitalization(s), duration of stay(s) and treatment(s) received:

   ____

   ____

5. Are you taking medication(s) for this condition? ___yes ___no.
   If Yes, list your medication(s):

Name of Medication	Dosage	Frequency

   If no, did your doctor recommend discontinuation? ___yes ___no. Date discontinued ________________

7. Any loss of time at work or restricted activities: ____

8. Results and dates of any special test/studies:

Dates	**Test / Studies results**
__________________________	____
__________________________	____

10. Name and address of treating physician:

Name of Physician	Address	Telephone Number

   Date last seen: ____________________

It is understood and agreed that the foregoing answers are true and shall be an attachment to my application for insurance and shall be the basis for the issuance of the Membership Certificate applied for, and that the omission or misstatement of any material information in answer to the foregoing questions shall void the membership certificate.

Signature of person treated (or parent / guardian if under 18)	Date