

SEIZURE QUESTIONNAIRE**Rohrer & Associates**

Insured's Name: _____ DOB: _____ State: _____ Sex: M / F
 Height: Ft. In. Weight: _____ Face Amount: _____
 Tobacco use in the past 5 years: No Yes Details: _____
 Producer: _____ State: _____ Phone: _____ E-mail: _____

Proposed Insured please answer the following:

1. What is your actual diagnosis?
2. When were you diagnosed?
3. What were your first symptoms?
 Details: _____
4. Please provide on the back of this page dates, tests, and results that have been completed to give you this diagnosis?
5. Date of your first episode?
 Details: _____
6. Date of your last episode?
 Details: _____
7. How often do they occur?
8. If you have seizures, do you lose consciousness? Yes No
 Details: _____
9. Do you have any warning prior to the seizure? Yes No
 Details: _____
10. Have you been told what causes your seizures? Yes No
 Details: _____
11. Do you have a valid driver's license? Yes No
 Details (restrictions): _____
12. Are you taking any medications? Yes No
 Name(s) and dosage(s): _____
13. Name(s), address(es) & phone number(s) of your physician(s) and date last consulted:

Additional Information (please use reverse side for additional space):

Date: _____ Insured's Signature: _____