



# EPILEPSY QUESTIONNAIRE TO BE COMPLETED BY ATTENDING DOCTOR

Proposed life assured: \_\_\_\_\_ Proposal No: \_\_\_\_\_

NRIC No: \_\_\_\_\_ Age: \_\_\_\_\_ Sex:  Male  Female

**We would appreciate if you could kindly complete this questionnaire**

1. Date of first consultation at your clinic for epilepsy

\_\_\_\_\_

2. Date of onset of epilepsy

\_\_\_\_\_

3. Nature and frequency of epileptic attacks

\_\_\_\_\_

4. Type of epilepsy

\_\_\_\_\_

5. Date of last attack

\_\_\_\_\_

6. Have there been any episodes of status epilepticus?  
If so, please indicate date

Yes  No

\_\_\_\_\_

7. Please state the medication and dosage of treatment given to control his/her epilepsy

\_\_\_\_\_

8. Is the epilepsy well controlled?

Yes  No

9. Does the above-named follow up with you for his/her epilepsy regularly?

Yes  No

10. Please give the date and results of any electroencephalogram carried out.

\_\_\_\_\_

\_\_\_\_\_

11. Are there any other relevant facts (e.g consumption of alcohol) which might have a bearing on his/her insurability? If so, please state full details.

\_\_\_\_\_

\_\_\_\_\_

Version 04/2020



This report has been prepared by:

\_\_\_\_\_  
Signature of Doctor

\_\_\_\_\_  
Clinic Rubber Stamp

Name : \_\_\_\_\_

Telephone No. : \_\_\_\_\_

Dated : \_\_\_\_\_

Kindly return this Questionnaire in a sealed envelope to the underwriter of our Company so as to maintain confidentiality of the information provided.

(We thank you for completing this questionnaire)

Name of Underwriter: \_\_\_\_\_

Date: \_\_\_\_\_