SEIZURE/EPILEPSY QUESTIONNAIRE
(complete all questions)

Name of primary applicant: _____ ID/SSN: _____

Name of person treated: _____ Relationship to applicant: _____

1. Please indicate type of seizure: _____Grand Mal _____Petit Mal _____Other (specify)
   _____Febrile _____Myoclonic _____Jacksonian
   _____Partial

   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 ___
   Name of Medication: **Dosage**: **Frequency (i.e., daily, as needed)**

   _____

   _____

   If no, did your doctor recommend discontinuation? Yes ____ No ___ Date discontinued _____

6. Name and address of treating physician: _____

   _____

   Date last seen? _____

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

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

Dates	**Test/Studies results**
_____	_____
_____	_____

9. Any other comments? _____

   _____

All of the above statements are true, complete and correctly recorded to the best of my knowledge. I understand Anthem Blue Cross and Blue Shield will rely on these statements when determining eligibility.

_____ _____

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

08/01