

Convulsion Questionnaire

First name : _____ Last name : _____
 Policy number : _____ Date of Birth : _____

1. Have you ever had or been told you had a convulsion or epilepsy? Yes No
 If yes, please indicate the type: Absence seizures (petit mal) Tonic-clonic seizures (grand mal) Nocturnal
 Other: _____
2. Date of first episode : _____ Date of last episode: _____
3. Frequency : _____
4. Convulsion(s) occur during the : Day Night Day and Night
5. Do you know the cause of your convulsions? Yes No
 If yes, please explain : _____
6. Do you have any warning of an episode? Yes No
 If yes, please explain : _____
7. Was any hospitalization required for this condition? Yes No
 If yes, dates and duration: _____
8. Was any time off work required for this condition? Yes No
 If yes, dates and duration: _____
9. Are you taking any medication for this condition? Yes No
 If yes, please state the name of the medication(s), strength, quantity and frequency: _____
10. Were any exams or tests performed for this condition? Yes No
 If yes, please indicate which of the following apply to your condition:
 Cranial X-rays EEG CT SCAN MRI Other: _____
11. Have you ever consulted a specialist or is there a pending consultation? Yes No
 If yes, please provide details (date and name of physician). _____
12. Do you have a driver's license? Yes No
 If no, please explain: _____
13. Name of family physician: _____

I declare that the above information is true and complete and acknowledge that it shall form part of my insurance application with Assumption Life.

 Signature of the person to be insured (parent or legal guardian if a minor) Date