La Capitale

EPILEPSY QUESTIONNAIRE

Last name

First name

Date of birth: Year Month Day

Application or Contract No.

1 Have you previously experienced:

a) Loss of consciousness? ☐ Yes ☐ No

b) Convulsions? ☐ Yes ☐ No

c) Epileptic seizures? ☐ Yes ☐ No

2 Date of first seizure: Year Month

3 Date of last seizure: Year Month

4 Number of seizures per year: _____

5 Have you had:

a) An electroencephalogram? ☐ Yes ☐ No **If so,** date: Year Month

b) Other tests? ☐ Yes ☐ No **If so,** specify.

Test/examination	Results (if applicable)	Date
		Year Month
		Year Month
		Year Month

6 Are you taking medication? ☐ Yes ☐ No **If so,** since when? Year Month

Specify the medications: _____

If not, have you ever taken any in the past? ☐ Yes ☐ No

If so, specify the medications, the reason and the cessation date. _____

La Capitale Civil Service Insurer Inc. | La Capitale Financial Security Insurance Company
625 Jacques-Parizeau St, Quebec QC G1R 2G5

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7 Name and address of your attending physician: _____

_____

8 Name and mailing address of all physicians or other healthcare professionals consulted for this condition.

Name	Address	Date of consultation
		Year Month
		Year Month
		Year Month

9 Please provide all relevant additional information. _____

_____

_____

_____

_____

I hereby acknowledge and agree that the answers to the questions in this questionnaire are true and complete.

Signed at _____ on this _____ day of _____ 20 _____ .

X _____
Signature of proposed insured or of legal guardian, if the proposed insured is under age 18 in Quebec or under 16 outside Quebec

X _____
Signature of witness

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