

EPILEPSY QUESTIONNAIRE

(To be completed by the medical attendant)

1. Life insured's details

Policy no. _____ Identity no. _____

Name of insured _____

1.1 At what age did the attacks first commence? _____

1.2 How frequent are the attacks? Provide details _____

1.3 When did the patient last have an attack?
Provide details _____

1.4 Do the attacks occur during the day or at night? _____

1.5 Do you lose consciousness during the attacks? YES ☐ NO ☐
If YES, provide details _____

1.6 Does the patient ever bite his/her tongue during an attack? YES ☐ NO ☐

1.7 Is the patient incontinent during an attack? ☐

1.8 Has the patient been diagnosed as: Grand mal YES ☐ NO ☐

Petit mal YES ☐ NO ☐

Temporal lobe YES ☐ NO ☐

Other _____

1.9 Does the patient take drugs to prevent further attacks? YES ☐ NO ☐
If YES, state medication and dosage _____

1.10 Has the patient previously had a head injury? YES ☐ NO ☐
If YES, describe severity _____

1.11 Has an MRI, EEG or brain scan ever been done? YES ☐ NO ☐
If YES, give details of doctor, date and result

D	D	M	M	Y	Y	Y	Y
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D	D	M	M	Y	Y	Y	Y
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D	D	M	M	Y	Y	Y	Y
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D	D	M	M	Y	Y	Y	Y
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D	D	M	M	Y	Y	Y	Y
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1.12 Further remarks _____

2. Notice to medical attendants

Holland Life will reimburse all medical accounts issued according to the insurance billing code.

General practitioner – insurance billing code A1403

Practice no. _____

Tel. no. _____ Fax no. _____

Full name _____

Email address _____ Mandatory

Postal address _____

Please send your account to either 086 693 7567 or ds_doctoraccount@holland.co.za.

3. Declaration by medical attendant

I declare that the statements above are true and complete.

Signature
(medical attendant) _____ **Date**

D	D	M	M	Y	Y	Y	Y
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Disclaimer

We respect and adhere to patient confidentiality and data privacy principles in relation to Personal Information. We will therefore only process this information for the purpose for which it is intended.