

**Identification**Policy number: Name of person to be insured: First Name of person to be insured: Date of birth:  /  /   
year / month / day**Section Loss of consciousness**1. Have you ever been told that you had a  Convulsion  Epilepsy  Syncope  Fainting spell Other types of loss of consciousness, specify: \_\_\_\_\_

If yes, please answer the following:

a) Date of first episode:  /  /   
year / month / day

b) How many episodes since? \_\_\_\_\_

c) Have you lost consciousness?  Yes  No

If yes, for how long? \_\_\_\_\_

d) Did you have precursor signs or symptoms before the episode?  Yes  Noe) Date of most recent episode:  /  /   
year / month / day

f) What is the length of time between episodes? \_\_\_\_\_

2. Indicate name and address of all physicians and clinics consulted as well as dates of consultations for this condition:

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**Loss of consciousness (...continued)**

3. Have any diagnostic tests been completed or recommended?  Yes  No

Did you have:  Skull X-Ray  Magnetic resonance imaging (MRI)  Electroencephalogram  Other tests: \_\_\_\_\_

If yes, specify date(s) and results of each test: \_\_\_\_\_

\_\_\_\_\_

4. What medications or treatments were you prescribed for this condition? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

5. Are you presently receiving any treatment or taking medication?  Yes  No

If yes, name of medication or type of treatment: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

6. What is your doctor's diagnosis or explanation of the cause of your condition? \_\_\_\_\_

\_\_\_\_\_

7. Have you ever been hospitalized for this condition?  Yes  No

If yes, provide dates and duration of time off work: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

