SEIZURE QUESTIONNAIRE

If you need more space, please attach additional page(s).

Name:

Case ID:	SSA Bar Code

1) Do you have seizures?

☐ Yes ☐ No

If yes:

a) What is the date of your first seizure?

b) What is the date of your last seizure?

c) What type of seizure(s) do you typically experience? (for example, tonic-clonic, focal, myoclonic, etc.)

d) How long does the seizure(s) typically last?

e) How often do your seizures occur?

f) List the approximate date(s) of your seizure(s) in the last 12 months.

g) Describe what happens before you experience a seizure:

h) Describe what happens to you while you are having a seizure:

i) Describe what happens to you immediately after having a seizure and how long before you can resume normal activity:

2) Describe activity(ies) that may trigger your seizure(s). For example, heights, exposure to flashing lights or patterns, drinking alcoholic beverages, stress, lack of sleep, etc.

3) Does your seizure disorder or the medication you take for seizures cause you any physical problems? For example, standing up, walking, seeing, breathing, or maintaining balance, etc.

☐ Yes ☐ No

If yes, explain:

4) Does your seizure disorder or the medication you take for seizures cause you any problems with understanding, remembering, or applying information?

☐ Yes ☐ No

If yes, explain:

5) Does your seizure disorder or the medication you take for seizures cause you any problems with interacting with others?

☐ Yes ☐ No

If yes, explain:

6) Does your seizure disorder or the medication you take for seizures cause you any problems with concentrating, persisting, or maintaining pace?

☐ Yes ☐ No

If yes, explain:

7) Does your seizure disorder or the medication you take for seizures cause you any problems with adapting or managing yourself?

☐ Yes ☐ No

If yes, explain:

8) If you have seen any health care professionals for your seizures and/or any of the problems discussed in questions 3-7 above, since you filed your claim, complete the chart below.

Name of Health Care Professional	Name of Condition They Treat	Address and Phone Number	Date of Last Visit and Next Scheduled Visit (if any)

9) If anyone (example: doctor, family member, non family member) has witnessed your seizure(s), please complete the chart below.

Witness Name	Address	Phone Number

10) Have you visited an emergency room for seizures? If so, when and where?

11) List current seizure medication(s) in the table below.

Medication, Dosage, and Frequency	Date Started	If Prescribed, Name of Health Care Professional	Side Effect(s)

12) If you listed names and contact information in response to questions 9 through 11 above, do we have your permission to contact them?

☐ Yes ☐ No

Name of person completing this form (Please print)	Date	Phone

Address

City	State	ZIP Code

Privacy Act Statement
Collection and Use of Personal Information

Sections 205(a), 223(d), 1614(a), and 1631(d) of the Social Security Act, as amended, allow us to collect this information, which we will use to determine benefits eligibility. Providing this information is voluntary, but not providing all or part of the information may prevent an accurate and timely decision on any claim filed. As law permits, we may use and share the information you submit, including with other Federal agencies, private medical and vocational consultants, contractors, and others, as outlined in the routine uses within System of Records Notices 60-0044, 60-0089, and 60-0320, available at www.ssa.gov/privacy. The information you submit may also be used in computer matching programs for Federal benefits eligibility or to recoup debts under these programs.

Paperwork Reduction Act Statement

This information collection meets the requirements of 44 U.S.C. § 3507, as amended by section 2 of the Paperwork Reduction Act of 1995. You do not need to answer these questions unless we display a valid Office of Management and Budget (OMB) control number. We estimate that it will take about 45 minutes to read the instructions, gather the facts, and answer the questions. ***Send only comments regarding this burden estimate or any other aspect of this collection, including suggestions for reducing this burden to:*** *SSA, 6401 Security Blvd, Baltimore, MD 21235-6401*.