

GSO: _____
App. No.: _____

NAME _____ DATE OF BIRTH _____

1. Date diabetes diagnosed: _____
2. Name and address of physician who made the diagnosis: _____

3. Reason a physician was consulted: _____

4. Name and address of current physician, if other than above: _____

5. Number of visits per year to physician: _____ Date of last visit: _____
6. Is urine sugar free? (a) now _____ (b) always _____ Date of last test: _____
7. What were the results of blood sugar determinations? _____

8. Are you on any special diet at this time? _____
9. Is the diet in conjunction with medication or without medication? _____
10. Total amount of insulin taken daily: _____ units.
(a) Of this total, indicate below the number of units of each type:
Plain _____ units N.P.H. _____ units
Protamine Zinc _____ units Other _____ units
Globin _____ units
(b) At what time is the insulin administered? _____
11. Has any drug been taken other than insulin? _____ If yes, type of drug _____
_____ Times of administration _____
12. Do you observe your diet regularly and/or take your anti-diabetic drug regularly? _____
13. Have you ever had a diabetic coma? _____ If so, give dates _____

14. Have you ever had insulin shock? _____ If so, give dates _____
15. Have you ever had:
(a) Infections, such as boils, carbuncles, etc.? _____ (d) High blood pressure? _____
(b) Eye trouble? _____ (e) Kidney trouble? _____
(c) Cardiovascular disease? _____ (f) Recurring or prolonged illness? _____
16. Date of last electrocardiogram: _____ Was it normal? _____
17. Date of last chest x-ray: _____ Was it normal? _____
18. If either the electrocardiogram or x-ray was taken by other than your current physician, record name and address of physician who made them: _____

DATE _____ APPLICANT'S SIGNATURE _____