

# Diabetic Questionnaire



## PLEASE PRINT

1 Name of Proposed Insured \_\_\_\_\_ Date of Birth \_\_\_\_\_

2 Height \_\_\_\_\_ ft. \_\_\_\_\_ in. Weight \_\_\_\_\_ lbs. Weight two years ago \_\_\_\_\_ lbs.

3 When were you first diagnosed with diabetes? Date \_\_\_\_\_

Name and address of physician \_\_\_\_\_

4 Are you receiving treatment or are you under supervision now?.....  Yes  No

If "Yes,": Date of last visit \_\_\_\_\_ Name and address of physician (if different from above) \_\_\_\_\_

5 How are you treating your diabetes?

Diet only

Insulin: Units \_\_\_\_\_ (per day)

Oral medication: Name and dosage \_\_\_\_\_

6 Do you regularly do home glucose monitoring? .....  Yes  No

Average range at home? \_\_\_\_\_

7 When was your last glycohemoglobin (Hemoglobin A1C) test? \_\_\_\_\_ Result? \_\_\_\_\_

Who performed the test? (Full name and address, if different from above) \_\_\_\_\_

9 (a) Have you ever been in (ketoacidosis) diabetic coma? ....  Yes  No - Number of times? \_\_\_\_ Dates \_\_\_\_\_

(b) Have you ever had insulin shock (hypoglycemia)? .....  Yes  No - Number of times? \_\_\_\_ Dates \_\_\_\_\_

(c) If 9(a) and/or 9(b) is answered "Yes," please advise the names of the physicians seen and the hospitals used for the most recent episodes of each. \_\_\_\_\_

10 Have you ever had or been told you had any of the following? (Please indicate "Yes" or "No")

Changes in vision or retinopathy .....  Yes  No

Kidney Disease .....  Yes  No

Hypertension .....  Yes  No

Eye Laser therapy.....  Yes  No

Albumin or protein in urine .....  Yes  No

High cholesterol.....  Yes  No

Heart disease .....  Yes  No

Numbness or neuropathy.....  Yes  No

Skin Ulcers .....  Yes  No

**Please provide details of any "Yes" answers, including names of physicians and dates:** \_\_\_\_\_

11 Have you ever had an abnormal electrocardiogram or stress test?.....  Yes  No

If "Yes," please provide date and by whom: \_\_\_\_\_

I hereby represent that all the statements and answers to the above questions are true and complete, and will be relied upon to determine my eligibility for insurance. I also understand that this signed form will be used during the underwriting process and any misstatements may affect my ability to obtain coverage.

\_\_\_\_\_  
Witnessed Signature of Proposed Insured

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Witness

\_\_\_\_\_  
Date