

DIABETES QUESTIONNAIRE

Proposed Insured's Name:

DOB:

Sex: M F

Tobacco Use: Yes No Amount:

Height: Ft. In. Weight:

Broker's Name:

Face Amount:

BGA:

Phone:

Fax:

Proposed Insured please answer the following:

1. Date you were diagnosed: _____ Age at diagnosis: _____
2. Classification: Insulin Non-Insulin Diet Gestational
3. Do you test your own blood sugar and urine? No Yes, How often?
4. Do you follow a diabetic diet or exercise? Yes No
5. Have you been diagnosed with or treated for any of the following?
 Retinopathy (Diabetes related eye problems) Kidney disease
 Neuropathy * Laser surgery
 Hypertension Protein in urine Heart conditions

Details:

*** If Neuropathy is present, please complete the Peripheral Vascular Questionnaire**

Very Important 6. When was your last glycohemoglobin (A1C) test done? _____

Who performed the test, and results: _____

7. Do you have any other major health problems? No Yes, Details: _____

8. Are you on any medication(s)? No Yes, Name(s) and dosage(s): _____

9. Have you had any reactions? No Yes, Type and frequency: _____

10. How often do you visit your physician?

Date of last visit: _____

11. Name and address of your physician(s): _____

12. Has case been shopped elsewhere, if so where?

13. Client's occupation?

Date: _____
