DIABETES QUESTIONNAIRE

Name	Date of Birth (dd/mmm/yy)	Application #

1. When were you diagnosed with diabetes (dd/mmm/yy):

Name and address of medical advisor now treating you and for how long (dd/mmm/yy)?

Do you follow a diabetic diet? ❍ Yes ❍ No

Do you participate in an exercise program? ❍ Yes ❍ No

Please provide full details of your present treatment:

❍ Diet & Exercise _____

❍ Oral medication (type & dosage) _____

❍ Insulin (type and number of units per day) _____

❍ Insulin Pump (type of insulin and number of units per day) _____

2. Height & Weight _____ in/cm _____ lbs/kg

a) Has your weight changed in the past 2 years? ❍ Yes ❍ No
b) Gained / Lost _____ lbs/kg

How often do you test your urine? _____ x per day _____ x per week _____ x per month

How often do you test your blood at home? _____ x per day _____ x per week _____ x per month

How often do you have your Hemoglobin A1C tested? _____

Date & result of last HgbA1C test: _____

Date & result of last Cholesterol test: _____ ❍ Never had one

Date & result of last Electrocardiogram (ECG / EKG): _____ ❍ Never had one

Date & result of last Chest x-ray: _____ ❍ Never had one

3. Have you ever required emergency treatment for diabetes? ❍ Yes ❍ No If yes, please give details below.

Does any member of your immediate family (parents or siblings) have a history of diabetes, high blood pressure, heart disease or stroke?
❍ Yes ❍ No If yes, please give details below.

Have you ever had any problems with ❍ Heart ❍ Kidneys ❍ Eyes ❍ Chest pain ❍ Fainting
❍ High blood pressure ❍ Numbness or tingling in the limbs

If yes, please give full details including dates, names and addresses of medical advisor consulted for these conditions.

I hereby declare that the above answers are complete and true, and agree that they shall form part of my application for the policy requested.

Signature of Applicant	Signature of Witness	Date (dd/mmm/yy)
X	X	