



## DIABETES QUESTIONNAIRE

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Proposed Insured's Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Sex:  M  F  
Tobacco Use:  Yes  No Amount: \_\_\_\_\_ Height: \_\_\_\_\_ Ft. In. Weight: \_\_\_\_\_  
Broker's Name: \_\_\_\_\_ Face Amount: \_\_\_\_\_  
Address: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

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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:

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:
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