

## DIABETES QUESTIONNAIRE

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_ Cigarette Smoker:  Yes  No Quantity per day: \_\_\_\_\_

1. Age at onset of diabetes? \_\_\_\_\_

2. What is the method of control? \_\_\_\_\_

3. Please indicate if you have had any of the following:

- EKG Abnormality
- insulin reaction
- diabetic coma
- eye trouble
- protein in urine
- skin ulceration
- amputation
- neuropathy / loss of feeling
- other \_\_\_\_\_

4. How often do you monitor blood sugar levels and what was the most recent reading?  
\_\_\_\_\_

5. Indicate most recent blood pressure reading (to the best of your knowledge): \_\_\_\_/\_\_\_\_

6. Last time you visited a physician? \_\_\_\_\_

7. Is your cholesterol below 200? \_\_\_\_\_

Name and address of all physicians/hospitals with medical records: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Notes/comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Signature of Proposed Insured: \_\_\_\_\_ Date: \_\_\_\_\_

Witnessed by: \_\_\_\_\_