

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: _____