Diabetic Questionnaire

Name: ______________________ Date of Birth: _______________________

Height: ________ Weight: _______ Sex: M/ F

Tobacco Usage: _______________ Face Amount: _____________________

___Term 10 15 20 30 ___UL

1. When was the proposed insured diagnosed? ____

2. Does the proposed insured receive any of the following treatment: (Check all that apply)
   ___Diet control
   ___ Oral medication (If yes, please provide name, dosage and frequency):
   ____
   ____
   ___Insulin (If so, how many units per day?) ____

3. How often does the proposed insured check their blood sugar? ____________________________

4. What is the proposed insured's most recent blood sugar reading? __________________________

5. What is the proposed insured's most recent A1C reading? ________________________________

6. How often does the proposed insured see their doctor for diabetes follow up? _________________
____

7. Has the proposed insured ever been is a diabetic coma? ___Yes ___No
(If yes, please provide the date and circumstances.)____
____

8. Is there any history of diabetes or heart disease in the proposed insured's family? ___Yes ___No
(If yes, please provide the relationship to the proposed insured, and the age of onset):
____
____
____

9. Have you had any of the following? (Explain to all that apply)
a. Eye trouble____
b. Heart Disease or Chest Pain____
c. Poor circulation or leg cramps____
d. Kidney disease ____
e. Neuropathy ____

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