

Diabetes Questionnaire

Name Male Female Age _____ Date of Birth _____

Tobacco Use No Cigarettes Other tobacco _____ Date quit? _____

State _____ Amount of Insurance _____ Type of Insurance _____

Occupation/Source of income: _____

1. Date Diabetes was diagnosed: _____

2. How often do you visit your physician? _____

3. Diabetes is controlled by: _____

Diet alone, Oral Medication- type of medication and amount _____

Insulin- type and amount: _____ Insulin pump _____

4. Test results: _____ Date: _____ Date: _____ Date: _____ Date: _____

Fasting Blood Sugar _____

Random Blood Sugar _____

Hgb A1C _____

How often do you monitor your blood sugars? _____

5. Other medications: _____

6. Do you have any of the following complications:

Neuropathy- mild, Neuropathy- moderate to severe, Retinopathy- mild, Retinopathy- moderate to severe, Kidney disease, Hypertension, Coronary artery disease or other heart problems, Protein in urine, Amputation.

Details of #6: _____

General Questions:

1. Do you have any other major health problems? No Yes – Details: _____

2. List all medications: _____

3. Height: _____ Weight: _____ Most recent blood pressure reading: _____

Agent Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____ Email: _____

The information gathered above will be used in the evaluation of the insurability of the applicant. All offers are tentative and are subject to verification of the submitted medical evidence and other criteria used in the underwriting of life insurance Copyright 2000 to 2004.

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