Diabetes Questionnaire

Agent: ______________________________ ***Phone:*** ______________ ***Fax:*** ________________
Client: ______________________________ ***DOB :*** ______________ ☐ ***Male*** ☐ ***Female***
Product/Face Amount: __________________________ ***Height:*** _________ ***Weight:*** ____________

✷ **TOBACCO/NICOTINE USE (*past or present*):** ☐ **YES***** ☐ **NO**
****Please provide details as to any past or present use of tobacco or nicotine products, including type of use, duration & frequency of use, date quit, etc.:*

✷ **When were you initially diagnosed with diabetes?** *(Please note the date that the diagnosis was provided and include a brief summary of the circumstances surrounding the diagnosis)*

✷ **Please indicate the date of your most recent visit to the physician managing your diabetes, and how often you are seen for management and follow-up:**

✷ **How is your diabetes currently being managed? (Check all that apply)**

- ☐ *Diet only*
- ☐ *Oral medication (include name & dosages on the medication list below below).*
- ☐ *Insulin (include type, amount/units per day on the medication list below below)*
- ☐ *Combination therapy (include details of combined therapy on the medication list below)*

✷ **MEDICATIONS -** *List ALL current medications, prescription and non-prescription (including vitamins, nutritional supplements, herbal preparations, etc) in the space provided below:*

MEDICATION	DOSE	MEDICATION	DOSE
1.		*5.*	
2.		*6.*	
3.		*7.*	
4.		*8.*	

✷ **Do you monitor your own blood sugar at home?**

- ☐ **YES -** *If Yes, how many times /day?*
- ☐ **NO**

✷ **Most recent blood glucose ("blood sugar") levels:**

**Result Obtained by physician's laboratory testing:* *Date/Time:*

**Result Obtained via home blood glucose monitoring:* *Date/Time:*

✷ **What was your most recent Glycohemoglobin (or "A1C") level obtained by your physician:**
(*please list your 3 most recent A1C levels*)**:**

- ***A1C level*** *(most recent):* % *Date obtained:*
- ***A1C level*** *(previous result)* % *Date obtained:*
- ***A1C level*** *(previous result)* % *Date obtained:*

✷ **Please indicate if you have been diagnosed with any of the following *specific* medical issues?**

❑ *Chest pain / Coronary Artery Disease*
❑ *Protein in the urine*
❑ *Elevated Cholesterol*
❑ *Retinopathy (eye damage)*
❑ *Hypertension*
❑ *Kidney damage*
❑ *Neuropathy/nerve damage*
❑ *Abnormal ECG*

✷ **FAMILY HISTORY:** (*Family history may be a factor in determining rate class*) **Is there a family history (*parent or siblings*) of the following conditions/disease onset prior to age 60:**

Cardiac Disease ☐ **YES** ☐ **NO**
Stroke or TIA ☐ **YES** ☐ **NO**
Diabetes ☐ **YES** ☐ **NO**
Cancer ☐ **YES** ☐ **NO**

Please provide details for any "YES" response below (attach additional sheet if necessary)

FAMILIAL RELATIONSHIP	SPECIFIC CONDITION(S)	AGE WHEN DIAGNOSED	CURRENT AGE (*if living*)	DECEASED (*list age @ time of death*)
FATHER				
MOTHER				
SIBLING 1				
SIBLING 2				

✷ **Do you have any other significant health issues or medical conditions not outlined or mentioned on this form?** (*Complete additional questionnaires, as indicated*)

☐ ***Condition(s)*** *- List treatment and current status:*

☐ **NONE** - *NO other medical conditions or health issues.*

✷ **Have you been previously declined, postponed or rated for life coverage? If so, please outline the circumstances in detail. Include date, insurance company name, reason for decision, as provided by the carrier and the nature of any prior application/submission (formal application vs. informal/trial submission, etc.)**

✷**Are there *<u>any</u>* other health factors, circumstances or information you consider to be important in evaluating you as an applicant for life insurance?**