

## **DIABETES QUESTIONNAIRE**

Height				Date of Birth:				
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			Weight	Cigarette Smoker:	☐ Yes	□ No	Quantity per day:	
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	1.	Age a	t onset of diabetes	?				
□ 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:	2.	What is the method of control?						
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:	3.	□ EKG Abnormality □ insulin reaction □ diabetic coma □ eye trouble □ protein in urine □ skin ulceration □ amputation □ neuropathy / loss of feeling						
6. Last time you visited a physician?	4.	How often do you monitor blood sugar levels and what was the most recent reading?						
7. Is your cholesterol below 200?	5.	Indicate most recent blood pressure reading (to the best of your knowledge):/						
Name and address of all physicians/hospitals with medical records:  Notes/comments:	6.	Last time you visited a physician?						
Notes/comments:	7.	Is your cholesterol below 200?						
	Na	me and	d address of all phy	vsicians/hospitals with me	dical recor	ds:		
Signature of Proposed Insured: Date:	No	tes/cor	mments:					
Witnessed by:							Date:	

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