

Diabetes Questionnaire

First Name : _____ Last Name : _____
 Policy Number : _____ Date of Birth : _____

1. Name and address of your attending physician: _____

2. At what age were you diagnosed with diabetes? _____

3. Treatment: Diet Oral medication Insulin
 If taking oral medication or insulin, please indicate the name, dosage and frequency of treatment.

Medication/Insulin	Dosage	Frequency
_____	_____	_____
_____	_____	_____

4. Do you regularly check your blood glucose (blood sugar level)? Yes No
 Please indicate the date, time and result of your last 3 readings

Date	Time	Result
_____	_____	_____
_____	_____	_____
_____	_____	_____

5. Has your blood pressure been checked in the last 6 months? Yes No
 If yes, please indicate the date and result of your last blood pressure readings.

Date	Result
_____	_____
_____	_____
_____	_____

6. Have you ever had any of the following conditions? Yes No

- Heart or circulatory disorder
- Elevated cholesterol
- Protein in the urine or other kidney disorder
- Neurological problem or numbness or a tingling sensation in the limbs
- Diabetic coma or an insulin reaction
- High blood pressure
- Vision impairment

Please give full details (date, diagnosis, treatment, result of any tests and name of physician consulted): _____

I declare that the above information is true and complete and acknowledge that it shall form part of my insurance application with Assumption Life.

Signature of the person to be insured (parent or legal guardian if a minor) _____ Date _____