**Application #** 

**Agent #**

# DIABETIC QUESTIONNAIRE (To be completed by Attending Physician)

**Proposed Life Insured** (Last name, First name, Middle name) 

**Date of Birth (mm/dd/yy)** 

How long has the Proposed Life Insured been your patient? 

Frequency of Visit 

(If Known) Date Diabetes was diagnosed (mm/dd/yy)

1. Does the patient report regularly for examination and advice? _________________
2. What treatment has been prescribed?
   a. Diet Only ( Please specify carbohydrates, protein and fat calculation in grams)
   b. Oral agent (Please specify drug and dosage)
   c. Insulin (Please specify type and dosage)
3. Does the patient control his condition
   - ❑ Poorly?
   - ❑ Moderately well?
   - ❑ Well?
4. What levels of blood and urine sugar has been recorded in the past two years?

| Date | | Date | |
|---|---|---|---|
| Fasting | | Fasting | |
| Nonfast | | Nonfast | |

5. Has the glycosylated hemoglbin (HbAIc) been measured? (If so, please give details)
6. Have any electrocardiograms been made on this patient?
   (If available, we will appreciated your mailing them to us for review, and they will be returned promptly. If not, just indicate findings in the space provided in #8 below)
7. Is there evidence of the following? (If so please give details)

| Type of Illness | YES | NO | Details to "YES" Answer |
|---|---|---|---|
| a. Retinopathy | | | |
| b. Nephropathy | | | |
| c. Neuropathy | | | |
| d. Ischemic Heart /disease | | | |
| e. Peripheral Vascular Disease | | | |

8. Please use the space below to amplify to the questions above and for any comments you care to make with regards to the patient's ability to handle the disease.

I affirm that the answers I have given above are complete and true to the best of my knowledge.

Dated at ___________________________ this _____ day of _____________________, 20 ______.

M.D.
Signature over Printed Name of ATTENDING PHYSICIAN

NB-DQAP-0602