

Diabetes Questionnaire

To be completed by the Medical Attendant

Name of Life Assured:.....
Application no.: Dated:.....

This questionnaire will form part of the application.

1. Please state date on which diabetes was first diagnosed:
a) How long has the applicant been under your treatment?
b) Are you aware of any previous treatment that the applicant may have taken?
.....
c) Is the applicant under regular medical supervision?
 No
 Yes
d) How compliant with therapy is the patient?

2. Please state date of most recent clinical examination.

3. What treatment is the applicant receiving for diabetes?
a) Dietary advice
b) Regular exercise
 No
 Yes – please provide details
c) Oral drugs
 No
 Yes – please state name and dosage
d) Insulin
 No
 Yes – please state name/type and total daily dosage

4. Does the applicant do home testing for blood sugar levels, e.g. with a glucometer?
 No
 Yes – what is the average blood sugar reading?

5. Has the applicant ever had a diabetic coma?
 No
 Yes – state whether hypoglycaemic or ketoacidotic, frequency and date of last coma.
.....

6. Are any of the following complications of diabetes known to be present? Ischaemic heart disease, nephropathy, neuropathy, peripheral vascular disease, retinopathy.
 No
 Yes – please provide details
.....

7. Is the blood pressure always below 125/80?
 Yes
 No – please state most recent readings with dates

<p>8. Have any of the following ever been done? Electrocardiogram; chest X-ray; lipid profile; glycosylated haemoglobin (HbA1c), microralbuminuria</p> <p><input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes</p> <p>NB: Where possible original ECG tracing, X-ray reports and test results should be forwarded with the completed form. These will be returned promptly after inspection.</p> <p>a) Please give results of last urine dipstick with special reference to presence or absence of microalbumin:</p> <p>b) Please give the date of the last HbA1c test as well as the reading:</p>
<p>9. Have you had occasion to refer this applicant to another medical practitioner?</p> <p><input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes – please provide details</p>
<p>Signed Date</p>