MEDICAL HISTORY QUESTIONNAIRE: DIABETES

Client Name: _____ Date of Birth: _____

Gender: ☐ Male ☐ Female Height: _____ Weight: _____

Tobacco Usage: Coverage Information:

☐ Never   Type: ☐ Term ☐ UL ☐ IUL

☐ Former   Date Stopped: _____   ☐ WL ☐ VUL ☐ Survivorship

☐ Current   Type: _____   Face Amount: _____

Premium Tolerance: _____

Proposed Insured's Existing Insurance			
Insurance Company	Face Amount	Year Issued	Replacement (Yes/No)

1. Date of Diagnosis _____

2. How often does your client visit his/her physician? _____

3. Date of last visit: _____

4. The client's diabetes is controlled by:

☐ Diet alone

☐ Oral medication (medication and dosage): _____

☐ Insulin (amount and units/day): _____

5. Please give the most recent glycohemoglobin (BhA1C): _____

6. Please check if your client has (had) any of the following:

☐ Chest pain or CAD   ☐ Protein in the urine   ☐ Elevated lipids

☐ Overweight   ☐ Neuropathy   ☐ Kidney disease

☐ Retinopathy   ☐ Abnormal EKG   ☐ Hypertension

7. Please list current medications

Name of Medication	Dosage	Reason

8. Are there any other health issues? (Additional Questionnaires may be required)   ☐ No   ☐ Yes

If yes, please provide details: _____

_____

_____

_____