COCOLIFE Building, 6807 Ayala Avenue Makati City 1226
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APPLICANT'S DIABETIC QUESTIONNAIRE

1. Name _____ Date of birth?_____

2. (a) Height? ____ m. ____ cm. (b) Weight? _____kilos (c) Weight one year ago? _____ kilos

3. Date glucose problem investigated? _____ What was the diagnosis: Diabetes? _____
   Impaired Glucose Tolerance? _____; Others _____

4. Name and address of physician that made diagnosis _____
   How long have you been under that physician's care?_____ Date of last visit? _____
   How often do you consult that doctor for examination and advice? _____
   Have you consulted any other physicians for this condition in the past 2 years? _____ If so, give names and addresses under 14 below.

5. What is your daily diet prescription? Carbohydrate ____ Gms. Protein ____ Gms. Fat ____ Gms.
   Do you measure or estimate your food portions from an exchange list? Measure • Estimate •
   If the above do not apply, what diet rules do you follow (Give details under14 below)

6. Do you use insulin? _____ If so, Type?_____ Daily dose? _____
   Do you use oral tablets?_____ If so, Kind?_____ How many per day? _____

7. How often do you test your urine for sugar? _____
   At what times of the day do you do so? _____
   What percentage of tests are positive for sugar? _____

8. How often do you have blood sugar determinations made?_____
   Give results of the tests for the past two years, indicating whether fasting or at other times.

	Results			Results	
Date	Fasting	Other Times	Date	Fasting	Other Times
1. _____	_____	_____	_____	_____	_____
2. _____	_____	_____	_____	_____	_____

9. Date you last had an electrocardiogram made? _____ An X-ray of chest? _____
   Give under 14 below, name and address of physician who made tests.

10. How many times have you been in coma, or had acidosis severe enough to require hospitalization? _____
    Have you ever had an insulin shock, or do you have insulin reactions? _____
    (Give details under 14 below)

11. Have you ever had: Elevated Blood Pressure?_____ Heart trouble?_____ Eye trouble? _____

    Kidney trouble?_____ Recurrent infections? _____ Other prolonged illness?_____
    If yes, give details under 14 below.

12. Latest serum cholesterol level_____ Date _____ Latest triglyceride level _____ Date_____

13. Do you now smoke cigarettes? No [ ] Yes [ ] #Pks?_____ If "No", have you ever smoke cigarettes?
    No [ ] Yes [ ] #Pks?_____ Quit when?_____

14. Use this page for additional explanations. Give complete information, including dates and addresses and attending physicians and names and addresses of hospitals.

Date _____ Applicant's Signature _____