PACIFIC CROSS VIETNAM

*The strength behind your insurance*

# DIABETES QUESTIONNAIRE

(To be completed by the applicant)

**Name, First name:** _____

**Date (day/month/year):** _____

This questionnaire will form part of the application.
If any questions below are answered "Yes", please supply full details below including dates and names of doctors and institutions where applicable.

1. Please state when diabetes was first diagnosed: _____

Type of diabetes? ❑ Type 1 ❑ Type 2 ❑ Unsure

(a) Are you under regular medical supervision for diabetes?

❑ No ❑ Yes – please state name and address of doctor _____

(b) How often do you consult your doctor? _____

Date of last visit? _____

2. Treatment:

a) Are you following an appropriate diet?

❑ No ❑ Yes – please provide details _____

b) Do you take regular exercise?

❑ No ❑ Yes – how frequent? _____

c) Are you on tablets?

❑ No ❑ Yes – please provide details _____

d) Are you on insulin?

❑ No ❑ Yes – please provide details _____

3. Has your treatment changed during the last 5 years?

❑ No ❑ Yes – please provide supply reasons and details

_____

4. Do you perform home blood sugar testing?

❑ No

❑ Yes – please state dates and results of the last three blood sugar readings

_____

5. Have you ever had any of the following?

| | | | | | |
|---|---|---|---|---|---|
| Diabetic coma | ❑ No | ❑ Yes | Eye trouble | ❑ No | ❑ Yes |
| Insulin shock | ❑ No | ❑ Yes | High blood pressure | ❑ No | ❑ Yes |
| Heart disease | ❑ No | ❑ Yes | Pain or burning of legs and feet | ❑ No | ❑ Yes |
| Kidney disease | ❑ No | ❑ Yes | Restricted circulation in lower limbs | ❑ No | ❑ Yes |
| Infections, e.g. boils and abscesses | ❑ No | ❑ Yes | Amputations | ❑ No | ❑ Yes |
| | | | Any other complications | ❑ No | ❑ Yes |
| Protein in urine | ❑ No | ❑ Yes | | | |

If yes, please provide dates, names and addresses of doctors consulted _____

_____

6. Have you ever been hospitalised?

❑ No ❑ Yes – please provide details _____

7. Have you ever undergone any of the following? Electrocardiogram; chest X-ray; lipid profile; glycosylated haemoglobin(HbA1c)

❑ No ❑ Yes – state date and result of test if know _____

**I declare that the answers I have given are, to the best of my knowledge, true and I have not withhelp any material information that may influence the assessment of acceptance of this proposal. I agree that this form will constitute part of my proposal for health insurance and that failure to disclose any material fact known to me may invalidate the contract.**

Signed: _____ Date (day/month/year): _____

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