BLUE CROSS VIETNAM

The strength behind your insurance

DIABETES QUESTIONNAIRE

(To be completed by the Medical Attendant)

Name, First name: _____

Date (day/month/year): _____

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: _____
8. Have any of the following ever been done? Electrocardiogram; chest X-ray; lipid profile; glycosylated haemoglobin (HbA1c), microalbuminuria
   ❑ No ❑ Yes
   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.
   Please give results of last urine dipstick with special reference to presence or absence of microalbumin:

   _____
9. Have you had occasion to refer this applicant to another medical practitioner?
   ❑ No ❑ Yes - please provide details: _____

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

4th Floor Continental Tower | 81-85 Ham Nghi Street | Nguyen Thai Binh Ward | District 1 | Ho Chi Minh City | Vietnam
Tel: (+84 8) 3821 9908 | Fax: (+84 8) 3821 9847 | Email: inquiry@bluecross.com.vn