MEDICAL HISTORY QUESTIONNAIRE: DIABETES

Client Name: ______________________ Date of Birth: ____________

Gender: ☐ Male ☐ Female Height: ____________ Weight: ____________

Tobacco Usage:

☐ Never

☐ Former Date Stopped: ____________

☐ Current Type: ____________

Coverage Information:

Type: ☐ Term ☐ UL ☐ IUL

☐ WL ☐ VUL ☐ Survivorship

Face Amount: ____________

Premium Tolerance: ____________

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

1. Date of Diagnosis ____________
2. Type 1 or Type 2 Diabetes? ☐ Type 1 ☐ Type 2 ____________
3. How often does your client visit his/her physician? ____________
4. Date of last visit: ____________
5. The client's diabetes is controlled by:
   - ☐ Diet alone
   - ☐ Oral medication (medication and dosage): ____________
   - ☐ Insulin (amount and units/day): ____________
6. Please give the most recent glycohemoglobin (HbA1c): ____________
7. 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
8. Please list current medications

Name of Medication	Dosage	Reason

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

If yes, please provide details: