

DIABETES QUESTIONNAIRE

Rohrer & Associates

Insured's Name: _____ DOB: _____ State: _____ Sex: M / F
Height: _____ Ft. _____ In. _____ Weight: _____ Face Amount: _____
Tobacco use in the past 5 years: No Yes Details: _____
Producer: _____ State: _____ Phone: _____ E-mail: _____

Proposed Insured please answer the following:

1. When were you first diagnosed with Diabetes?
2. At what age were you diagnosed?
3. What is your Diabetes classification (please circle)?
Insulin Non-Insulin Diet Gestational
4. Do you test your own blood sugar and urine? Yes No
How often?
5. Do you follow a diabetic diet or exercise? Yes No
6. Have you been diagnosed or treated for any of the following (please circle all that apply)?
Retinopathy (Diabetes related eye problems) Heart Conditions Hypertension
Neuropathy* Kidney disease Protein in urine
Laser surgery
**If neuropathy is present, please complete the Peripheral Vascular Questionnaire*
Details: _____
7. When was your last glycohemoglobin (A1C) test done?
What was the result of the test?
8. Do you have any other major health problems? Yes No
Details: _____
9. Are you on any medications(s)? Yes No
Name(s) and dosage(s): _____
10. Have you had any reactions? Yes No
Type(s) and frequency(s): _____
11. How often do you visit your physician?
Date of last visit?
12. Name, address & phone number of your physician(s): _____

Additional Information (please use reverse side for additional space):

Date: _____ Insured's Signature: _____