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. How often does your client visit his/her physician? _____
3. Date of last visit: _____
4. The client's diabetes is controlled by:
   - ☐ Diet alone
   - ☐ Oral medication (medication and dosage): _____
   - ☐ Insulin (amount and units/day): _____
5. Please give the most recent glycohemoglobin (HbA1c): _____
6. 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

7. Please list current medications

Name of Medication	Dosage	Reason

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

If yes, please provide details:

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