DIABETES QUESTIONNAIRE

Global Insurance Resources Group Inc.
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CLIENT: NAME _____ [ ] M [ ] F, DATE OF BIRTH _____

AGE_____ HT _____ WT_____ STATE _____

AMOUNT REQ. $_____ MAX. ANNUAL PREMIUM $_____

TYPE OF INSURANCE: [ ] PERM [ ] TERM YRS. LEVEL _____

TOBACCO USE: [ ] NO [ ] YES, DETAIL_____

REPLACING? [ ] NO [ ] YES CURRENT ANN. PREM. $ _____

LAST LIFE INSURANCE APP. YEAR:_____ COMPANY_____
ACTION_____

AGENT: NAME_____ PHONE_____FAX_____

ADDRESS_____ CITY_____ ST_____ ZIP _____

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1. CLIENT'S AGE AT ONSET OF DIABETES_____

2. WHAT IS THE METHOD OF CONTROL?
[ ] DIET ONLY
[ ] DIET AND ORAL MEDICATION (S)*
[ ] DIET AND INSULIN INJECTION
***LIST MEDICATIONS:_____**

3. HOW MANY TIMES A DAY IS CLIENT'S INSULIN ADMINISTERED?
[ ] ONE OR TWO TIMES PER DAY
[ ] THREE OR MORE TIME PER DAY
[ ] INSULIN PUMP

4. HOW OFTEN ARE CLIENT'S BLOOD SUGAR LEVELS MONITORED?
[ ] ONE OR TWO TIMES PER DAY
[ ] THREE OR MORE TIME PER DAY

5. PLEASE INDICATE ANY OF THE FOLLOWING EXPERIENCED;
[ ] EKG ABNORMALITIES
[ ] INSULIN REACTIONS
[ ] DIABETIC COMA
[ ] EYE TROUBLE
[ ] HEART TROUBLE

8. HOW LONG HAS THE GLYCOHEMOGLOBIN LEVEL REMAINED CONSTANT?
[ ] 0 TO 6 MONTHS
[ ] 6 TO 12 MONTHS
[ ] OVER A YEAR

9. DATE OF CLIENT'S LAST VISIT TO A PHYSICIAN:
[ ] 0 TO 6 MONTHS AGO

[ ] 6 TO 12 MONTHS AGO

[ ] OVER 1 YEAR AGO

10. LIST THE LAST CHOLESTEROL READING, IF KNOWN:
_____HDL RATIO _____

11. LIST THE LAST BLOOD PRESSURE READING, IF KNOW:
_____SYSTOLIC
_____DIASTOLIC

12. CLIENT'S OCCUPATION _____

13. HAS A PARENT, BROTHER OR SISTER DIED PRIOR TO AGE 65,OTHER THAN BY ACCIDENT?

[ ] PROTEIN IN URINE
[ ] SKIN ULCERATION
[ ] AMPUTATIONS
[ ] NEUROPATHY OR LOSS OF FEELING

6. PLEASE DETAIL ANY INDICATIONS FROM QUESTION NUMBER 5, SUCH AS: TYPE OF; DATE OF; FREQUENCY OF OCCURRENCE

_____

_____

_____

_____

7. HAS THE CLIENT HAD A GLYCOHEMOGLOBIN (A1C) TEST DURING THE PAST SIX MONTHS?
[ ] NO [ ] YES, PLEASE DETAIL LEVEL:
[ ] BELOW 7.5
[ ] 7.6 TO 10
[ ] 10.1 TO 13
[ ] ABOVE 13

[ ] NO [ ] YES, PLEASE DETAIL

_____

_____

14. DOES THE CLIENT EXERCISE THREE OR MORE TIMES PER WEEK?

[ ] NO [ ] YES, PLEASE DETAIL _____

_____

15. PLEASE LIST ANY OTHER IMPAIRMENTS OR ILLNESSES ALONG WITH ANY AND ALL MEDICATIONS CURRENTLY BEING TAKEN, INCLUDE THE DOSAGE AND FREQUENCY OF EACH:

_____

_____

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