

## DIABETES QUESTIONNAIRE

(To be completed by the life to be assured)

Full name of life to be assured

Proposal number /Application number

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1. Date or year of diagnosis

**2. Weight**

a. Weight at the time of diagnosis (if known) \_\_\_\_\_ Kg

b. Present weight. \_\_\_\_\_ Kg

**3. Are you on:**

a) Oral drug treatment? State names of drugs and dose received.

b) Insulin (type / dose)? And frequency of injections per day.

**4. How often do you check your blood sugar?**

**5. Last blood sugar reports with dates and year**

Fasting : \_\_\_\_\_

Post lunch : \_\_\_\_\_

Random : \_\_\_\_\_

**6. Are you monitoring your blood sugar at home.**

Yes  No

**7. Have you been subjected to (where Yes, please attach the reports)**

Yes  No

a) Estimation of lipids: Total S. cholesterol, Serum Triglycerides, HDL Cholesterol.

Yes  No

b) Glycosylated hemoglobin estimation.

Yes  No

If so, how often and based on these reports were you told that your control is good/fair/poor.

c) Serum Creatinine

Yes  No

**8. Do you smoke cigarettes /Bidis / Cigar etc,**

If yes please mention the quantity and duration of smoking.

Yes  No

\_\_\_\_\_/day since \_\_\_\_\_ yrs.

Blood Pressure

a. What was the blood pressure

1. At the time of diagnosis \_\_\_\_\_

2. At present \_\_\_\_\_

b. Are you on any antihypertensive drugs ? If yes, please name the drugs

**8. Do you smoke cigarettes /Bidis / Cigar etc,**

If yes please mention the quantity and duration of smoking.

\_\_\_\_\_/day since \_\_\_\_\_ yrs.

**9. How often have you been subjected to recording an Electrocardiogram(ECG).**

Please submit the last report.

**10. Where you advised stress testing at any time during the course of your disease.**

Yes  No

If yes, please submit the reports.

**11. Have you ever suffered from any of these conditions since the diagnosis of diabetes:**

a. Loss or diminished sensation in the hands and feet

Yes  No

b. Chest pain

Yes  No

c. Unstable angina

Yes  No

d. Foot problem associated with diabetes

Yes  No

e. Foot infection and ulceration

Yes  No

f. Recurrent urinary tract infection

Yes  No

g. Recurrent skin infection

Yes  No

**12. Were you ever hospitalized for any of the following?**

- a. Investigation and management by a cardiologist.
  - b. Treatment of hypoglycemia or uncontrolled diabetes
  - c. or hyperglycemia or diabetic ketosis or coma.
- If Yes, give details.

Yes  No  
 Yes  No  
 Yes  No

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**13. Have you been told by your treating doctor that for proper control of your diabetes insulin treatment is required?**

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**14. Were you ever examined for evidence of diabetic changes in the eye**

If Yes, please give findings.

Yes  No

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**15. Do you have any family history of diabetes?**

If Yes, please give details.

Yes  No

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I declare that the answers I have given are, to the best of my knowledge, true and that I have not withheld any material information that may influence the assessment or acceptance of this application.

I agree that this form will constitute part of my application for life assurance and that failure to disclose any material fact known to me may invalidate the contract.

Place: \_\_\_\_\_

Date: \_\_\_\_\_

\_\_\_\_\_  
Signature of the Life to be Assured