HERMANN SONS LIFE

Diabetes Questionnaire

TO BE COMPLETED BY APPLICANT

PLEASE PRINT IN BLUE OR BLACK INK ONLY

Name _____ **Date of Birth** _____

Source _____ **Date** _____

1. Name and address of physician(s) consulted for diabetes? (If Kaiser, obtain patient number)

   Name _____

   Address _____

   Date last consulted? _____

   Details _____

   How often do you consult your physician? _____

2. Date of diagnosis? _____

   What were your symptoms? _____

   _____

3. Do any of your parents, brothers or sisters have diabetes? ☐ Yes ☐ No Details

   _____

4. How is your diabtes controlled? (Check all that apply) ☐ Diet ☐ Oral Medication(s) ☐ Insulin

   List medications _____

   _____

5. Do you test your own blood sugar? ☐ Yes ☐ No How often? _____

   Readings: Fasting _____ Non-fasting _____

6. Any loss of work or disability associated with diabetes? ☐ Yes ☐ No Details

   _____

7. Have you ever had:

a.	Diabetic coma	☐ Yes	☐ No	e.	Kidney trouble	☐ Yes	☐ No
b.	Insulin shock	☐ Yes	☐ No	f.	Neuropathy or numbness/tingling	☐ Yes	☐ No
c.	Heart trouble	☐ Yes	☐ No	g.	Retinopathy or eye problems	☐ Yes	☐ No
d.	High blood pressure	☐ Yes	☐ No				

   Details _____

8. Have you ever been hospitalized due to your diabetes? ☐ Yes ☐ No

   If yes, when and where? _____

   _____

_____ _____

Signature of the Proposed Insured Date