Diabetic Questionnaire

Name ______________________________ **Sex** M F **Date of Birth** _________________________

Height _________________ **Weight** ______________ **Smoker?** Y N **State** ________

Coverage Desired? _____________________ **Amount** ________________ **Plan Desired?** _____________

Have you ever been Rated or Declined for insurance? If YES Complete details please

____

When was your Diabetes first diagnosed? ____
What Diabetic symptoms did you exhibit? ____
Name and Address of present doctor? ____
How often do you visit your doctor? ___________________________ **Date of last visit** _______________

Medication required to control your Diabetes **(Please indicate all that apply)**
Diet only Y N **Oral Medication** Y N **Insulin** Y N **Insulin and Oral** Y N
Please indicate Daily Dosage ____
Do you regularly test your urine for sugar? Y N **How often do you test?** _____________________
How often is urine sugar present? ____

Please indicate if you have ever had any of the following: **(Please indicate all that apply)**
Diabetic Coma Y N **Insulin Shock** Y N **Kidney Disease** Y N
Heart Problems? Y N **Eye Problems** Y N **Neuritis** Y N

What have been your recent Blood Pressure readings? ______________________ **On Medication?** Y N
What has been your recent Cholesterol readings? __________________________ **On Medication?** Y N

Do any of your parents, brothers, sisters, or children have diabetes? Y N
If YES Complete details please ____

Do you have any Family History of Heart or Cardiovascular Disease? _______________________________
____

Please indicate if you have ever had any of the following: **(Please indicate all that apply)**
Electrocardiograms Y N **Stress Tests** Y N **X-Rays** Y N
Dates and Results please ____

What Lifestyle Changes have you made to treat your illness? ______________________________________

Please list all medications being taken: ____
____

Do you have any other major health problems? **(example: cancer, etc)?**
____

Broker Submitting Questionnaire: ____
Address ____
Phone: __________________________ **FAX:** __________________________ **E-mail:** ______________________

Please send completed form: **Victorson Associates, Inc.** **PO Box 863** **Smithtown, NY 11787**
You may Fax to: **(631) 265-7054** **or** **E-mail to:** **vainc@victorson.com**