DIABETES

PRELIMINARY UNDERWRITING QUESTIONNAIRE

Client: **Gender:** M◯F◯ **DOB:**

Height: **Weight:**

Coverage Desired? **Amount?** **Plan Desired?**

If your client has diabetes, please answer the following:

DIABETES HISTORY

1. **What was the date of initial treatment or diagnosis?**
2. **How often does your client visit their physician?**
3. **Please note the date of your client's last visit to their physician:**
4. **What is the client's diabetes controlled by?** *Select all that apply.*

☐ Diet alone
☐ Oral medication (medication and dosage)
☐ Insulin (amount of units/day)

5. **Please note your client's most recent blood sugar reading:**
6. **Does your client monitor their own blood sugar?** ◯Yes ◯No
7. **If available, please give the most recent glycohemoglobin (HbA1c) or fructosamine level:**
8. **Has your client had any of the following?** *Select all that apply.*

☐ Chest pain or coronary artery disease
☐ Protein in urine
☐ Neuropathy
☐ Retinopathy
☐ Abnormal ECG
☐ Overweight
☐ Elevated lipids
☐ Kidney disease
☐ Black out spells
☐ Hypertension

CURRENT STATE

9. **Please list current medications:**
10. **Has your client smoked cigarettes in the last 12 months?** ◯Yes ◯No
11. **Does your client have any other major health problems (*ex: cancer, etc.*)?** ◯Yes ◯No

If yes, please give details:

ADDITIONAL COMMENTS

Do you have any additional comments?

Advisor:

Date:

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