

## Diabetic Questionnaire

**To be completed by attending Doctor**

Proposed Life : _____ Proposal No. _____	
NRIC No. : _____ Age : _____ Sex : ( ) Male ( ) Female	
We would appreciate if you could kindly complete this questionnaire	
(1) (a) Date of first registration at your clinic	
(b) Date diabetes was first diagnosed	
(c) Date of onset and duration of his/her diabetes	
(2) Name and address of any other Doctors who has treated the proposed life assured for diabetes.	
(3) How is the proposed life assured diabetes controlled? ( ) By Diet Control ( ) Oral Hypoglycemic agents ( ) Insulin	
<b>NAME OF DRUGS USED</b>	<b>DOSAGE</b>
<b>DATE TREATMENT STARTED</b>	
(4) (a) Does the proposed life assured maintain regular follow up at your clinic for his/her diabetes?	<input type="checkbox"/> Yes <input type="checkbox"/> No
(b) Does the proposed life assured follow your advice regarding his/her diet control and medication?	<input type="checkbox"/> Yes <input type="checkbox"/> No
(5) Please record the last three urine examination results as recorded by your clinic	
<b>DATE</b>	<b>SUGAR</b>
<b>ALBUMIN</b>	<b>MICROSCOPIC EXAMINATION</b>
a.	
b.	
c.	
(6) Please provide us with the last two blood test results of the following if carried out :-	
<b>NO.</b>	<b>DATE</b>
<b>RESULTS</b>	<b>DATE</b>
<b>RESULTS</b>	
a. Blood Glucose (Fasting)	
b. Blood Glucose (2hrs. Post prandial)	
c. Glycosolated Heamoglobin (HbA1c)	
d. Blood Lipids Profile	
e. Others (Please specify)	
(7) Has the proposed life assured ever been hypertensive? If the answer is "YES", please state date and level of his/her highest blood pressure reading	<input type="checkbox"/> Yes <input type="checkbox"/> No
(8) How well is his/her diabetes controlled -	<input type="checkbox"/> a) Very well <input type="checkbox"/> b) Moderate <input type="checkbox"/> c) Poor

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(9) Does the proposed life assured smoke cigarettes? If the answer is "YES", please provide details :-  Amount smoked (                    ) Duration (                    )	<input type="checkbox"/> a) Do not know <input type="checkbox"/> b) Yes he/she smokes <input type="checkbox"/> c) Non smoker
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(10) Has the proposed life assured ever suffered from any of the following?	
	Yes                    No
Diabetic Coma	<input type="checkbox"/> <input type="checkbox"/>
Peripheral Artery disease	<input type="checkbox"/> <input type="checkbox"/>
Diabetic Nephropathy	<input type="checkbox"/> <input type="checkbox"/>
Unexplained proteinuria	<input type="checkbox"/> <input type="checkbox"/>
Diabetic retinopathy	<input type="checkbox"/> <input type="checkbox"/>
Coronary Artery Disease	<input type="checkbox"/> <input type="checkbox"/>
	Date of event                    (                    )
	Amount of protein                    (                    )
	Grade                    (                    )
	Date of diagnosis                    (                    )

(12) Do you know of any other relevant factors that may assess us to his/her medical impairment and future prognosis?  If the answer is "YES", please provide details:-	<input type="checkbox"/> Yes <input type="checkbox"/> No
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**KINDLY RETURN THIS FORM IN A SEALED ENVELOPE TO THE UNDERWRITER OF OUR COMPANY SO AS TO MAINTAIN CONFIDENTIALITY OF THE INFORMATION THAT YOU HAVE PROVIDED.**

This report has been prepared by:-

  
  
  
  
  
  
  
  
  
  

Signature of Doctor : \_\_\_\_\_ Clinic Rubber Stamp : \_\_\_\_\_

Dated : \_\_\_\_\_ Telephone No. : \_\_\_\_\_