AXA AFFIN

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

NAME OF DRUGS USED	DOSAGE	DATE TREATMENT STARTED

(4) (a) Does the proposed life assured maintain regular follow up at your clinic for his/her diabetes?	☐ Yes ☐ No
(b) Does the proposed life assured follow your advice regarding his/her diet control and medication?	☐ Yes ☐ No

(5) Please record the last three urine examination results as recorded by your clinic

	DATE	SUGAR	ALBUMIN	MICROSCOPIC EXAMINATION
a.				
b.				
c.				

(6) Please provide us with the last two blood test results of the following if carried out :-

NO.		DATE	RESULTS	DATE	RESULTS
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	☐ Yes ☐ No
(8) How well is his/her diabetes controlled -	☐ a) Very well ☐ b) Moderate ☐ c) Poor

(9) Does the proposed life assured smoke cigarettes?
If the answer is "YES", please provide details : -

Amount smoked ( )
Duration ( )

☐ a) Do not know
☐ b) Yes he/she smokes
☐ c) Non smoker

(10) Has the proposed life assured ever suffered from any of the following?

	Yes	No		
Diabetic Coma	☐	☐	Date of event	( )
Peripheral Artery disease	☐	☐		
Diabetic Nephropathy	☐	☐		
Unexplained proteinuria	☐	☐	Amount of protein	( )
Diabetic retinopathy	☐	☐	Grade	( )
Coronary Artery Disease	☐	☐	Date of diagnosis	( )

(11) Were any of the following carried out on this proposed life assured?

Name Of Test	Date Of This Test	Normal	Abnormal	Details If Abnormal Findings
Resting ECG				
Stress ECG				

(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:-

☐ Yes ☐ No

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. ____________________