La Capitale
Financial Security

DIABETES QUESTIONNAIRE

APPLICANT'S NAME: ______________________ DATE OF BIRTH: ____ / ____ / ______ (MM DD YYYY)

1. Type of Diabetes? ☐ **Type I** (Insulin-dependent diabetes mellitus, IDDM)
   ☐ **Type II** (Non–insulin-dependent diabetes mellitus, NIDDM)

2. Date of Diagnosis? ______________________

3. Please indicate type of treatment and provide name, dosage and frequency:

	Dosage	**Frequency**
☐ Diet	________	________
☐ Oral Medication(s)	________	________
☐ Insulin	________	________

4. Any change in the treatment since diagnosis? . . . . ☐ Yes ☐ No

5. (a) Name and address of your attending physician:

   Name: ______________________

   Address: ______________________

   (b) How often do you visit your physician? ______________________

   (c) What was the date of your last visit? ______________________

6. (a) How often do you check your glucose levels?
   ☐ Daily (self check)
   ☐ Weekly (self check/by doctor)
   ☐ Monthly (only monitored by doctor)

   (b) What are the normal / last readings? ______________________

   (c) Have you ever had albumin present in urine? . . . . ☐ Yes ☐ No

7. Check if you have a history of:
   ☐ Diabetic Coma ☐ Insulin Shock ☐ Leg or Foot Ulcers
   ☐ Heart Disease ☐ Kidney Disease ☐ Vision Problem (Retinopathy)
   ☐ High Blood Pressure ☐ High Cholesterol
   ☐ Numbness/tingling in the limbs

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

   If "Yes", provide details. ______________________

   ____

9. Have you ever taken any time off work due to diabetes or any associated conditions? . . . . . . ☐ Yes ☐ No

   If "Yes", provide details. ______________________

   ____

10. Do you have any family history of diabetes? . . . . ☐ Yes ☐ No

I understand that this questionnaire will form part of the application for insurance I have made to La Capitale Financial Security Insurance Company. I certify that the answers are true and complete.

______________________ **Signature of Proposed Insured** ______________ **Date**