

Diabetes Questionnaire

(To be filled by the Applicant)

Name of the Life Insured	
Application Number	

- When was your diabetes or IFG or IGT or increased blood sugar first diagnosed? _____
- Please state the type of diabetes you are suffering from:
 - ☐ a) Type 1 (Insulin dependent)
 - ☐ b) Type 2 (Non-insulin dependent)
 - ☐ c) Gestational diabetes
- What is the nature of your treatment at present? ☐ Exercise and Diet Control ☐ Tablets ☐ Insulin
 If 'Yes' for insulin or tablets, mention the type: _____
 Dosage: _____
 What was the earlier treatment? _____
- Do you suffer from any complaint related to diabetes like increased thirst, increased hunger, frequent urination, unexplained weight loss, fatigue, dry mouth, etc.:

 Have you had problems with infections? ☐ Yes ☐ No
 Please mention what kind of infection (Like acne, burning on urination, frequent colds, itching in groin or feet, boils).

- Do you test blood sugar? How often: ☐ Monthly ☐ Randomly ☐ Half yearly ☐ Yearly
 Please mention your last two readings and dates: I.) _____ II.) _____
 How often do you get a urine test done to check for sugar? ☐ Monthly ☐ Half-yearly ☐ Annually ☐ Randomly ☐ Never
- Have you ever been told you have:
 - a) High blood pressure ☐ Yes ☐ No
 - b) Eye abnormality ☐ Yes ☐ No
 - c) Nerve problem ☐ Yes ☐ No
 - d) Kidney problem ☐ Yes ☐ No
 - e) Heart disease ☐ Yes ☐ No
- Do you have any history of uncontrolled blood sugar continuously for more than 15 days or diabetic Coma or insulin shock, hypoglycaemia or long non-healing wound? ☐ Yes ☐ No
 If 'Yes', please provide details: _____

- Have you ever undergone medicals like TMT, chest x-ray, ECG or any other test? ☐ Yes ☐ No
 If 'Yes', please mention the test results: _____

 Has there been a change in your treatment in the last 2 years? If 'Yes', please mention when and why. Please attach your prescriptions/consultation notes:

- Have you ever been hospitalised for complications of diabetes? If 'Yes', please share your discharge summary: _____

- Do you consume alcohol, smoke or use tobacco in any form? ☐ Yes ☐ No
 If 'Yes':
 - a) a) How many cigarettes/bidis/cigars/pipes do you smoke per day? _____
 - b) How much alcohol do you consume per day? _____ ml/day
 - c) Your alcohol of choice: Wine / Beer / Whiskey / Gin / Rum / Vodka / Spirit
 (Please tick (✓) whichever is applicable)

I hereby declare, and agree that the above particulars and answers are complete and true; and this questionnaire will form a part of the contract of the desired insurance on my life.

Signature of the Life Insured

Signature of the Declarant

Signature of the Life Insured