Return to - jim@uswolfe.com or Fax to 815-377-3556

DIABETES QUESTIONNAIRE

Insured's Name: DOB: State: Sex: M / F

Height: Ft. In. Weight: Face Amount:

Tobacco use in the past 5 years: No Yes Details:

Producer: State: Phone: E-mail:

Proposed Insured please answer the following:

1. When were you first diagnosed with Diabetes?

2. At what age were you diagnosed?

3. What is your Diabetes classification (please circle)?
   Insulin Non-Insulin Diet Gestational

4. Do you test your own blood sugar and urine? Yes No
   How often?

5. Do you follow a diabetic diet or exercise? Yes No

6. Have you been diagnosed or treated for any of the following (please circle all that apply)?
   Retinopathy (Diabetes related eye problems) Heart Conditions Hypertension
   Neuropathy* Kidney disease Protein in urine
   Laser surgery
   If neuropathy is present, please complete the Peripheral Vascular Questionnaire
   Details:

7. When was your last gylcohemoglobin (A1C) test done?
   What was the result of the test?

8. Do you have any other major health problems? Yes No
   Details:

9. Are you on any medications(s)? Yes No
   Name(s) and dosage(s):

10. Have you had any reactions? Yes No
    Type(s) and frequency(s):

11. How often do you visit your physician?
    Date of last visit?

12. Name, address & phone number of your physician(s):

Additional Information (please use reverse side for additional space):

Date: _____ Insured's Signature: _____