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DIABETIC QUESTIONNAIRE

To be completed by the applicant

APPLICANT INFORMATION

NAME OF APPLICANT _____ DATE OF BIRTH ____ ____ ____ (DAY MONTH YEAR)

DETAILS

1. Present weight _____ lbs ☐ kg ☐

2. When was diabetes first diagnosed? _____

3. Name and address of your Physician

4. How often do you visit the doctor?

5. Date of last visit _____

6. Indicate if you currently have or had a history of any of the following:

- ☐ Eye or vision problems
- ☐ Coronary artery disease
- ☐ Insulin shock or diabetic coma
- ☐ Neuropathy (numbness, pins & tingling needles)
- ☐ Kidney or bladder problems
- ☐ Stroke
- ☐ Hypertension
- ☐ Leg/feet ulcers
- ☐ Chest pain or heart disease

If selected, please provide details:

7. Do you have any other medical conditions?

☐ YES ☐ NO If "YES", please provide details.

8. Recent BP readings:

DATE: BP READING:

9. Provide most recent blood sugar, HbA1C and cholesterol results:

Date: _____ Blood sugar _____

Date: _____ HbA1C _____

Date: _____ Cholesterol _____

10. Current treatment for diabetes:

Treatment Options	Medication name & dosage	Date Started
Diet	☐ Diet Only	
Oral Medications		
Insulin		

SIGNATURE

A photocopy or an electronic reproduction of this document will be as valid as the original.

Applicant's Signature: _____ Date: _____

PLEASE RETURN FORM TO:
The Wawanesa Life Insurance Company, 400-200 Main Street, Winnipeg, MB R3C 1A8
TOLL FREE: 1-888-997-9965 FAX: 1-888-985-3872 WEBSITE: wawanesalife.com

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