



# INSURANCE DESIGNERS

Insurance Designers of Central Texas, LLC

## Diabetes Questionnaire

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Phone 512-257-9700 FAX 512-257-9701

Today's Date: \_\_\_\_\_ Agent: \_\_\_\_\_  
 Full Name: \_\_\_\_\_ Male or Female? \_\_\_\_\_  
 Height and weight: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

1. Month and year diagnosed: \_\_\_\_\_ Age at diagnosis: \_\_\_\_\_ Type 1 or 2 ?
2. What medication do you take, reason, dosage and how often? If insulin, include number of units per day.
3. How often do you see your doctor?  
 \_\_\_ Every six months      \_\_\_ Every 12 months      \_\_\_ Other (explain):
4. Do you monitor your own blood sugar? \_\_\_ Yes \_\_\_ No  
 If yes, how often? \_\_\_\_\_ Average reading? \_\_\_\_\_
5. IMPORTANT: What have been your a1c readings for the past two years? Please list dates and readings. Please call your doctor's office and ask if you are not sure.
6. Has your weight remained stable in the past year? \_\_\_ Yes \_\_\_ No  
 If no: Lost \_\_\_\_\_ pounds OR Gained \_\_\_\_\_ pounds
7. Please indicate type of tobacco EVER used:  

Type:	Amount per (circle frequency):	Date last used:
___ Smokeless	___ per day/month/year	_____
___ Cigarettes	___ per day/month/year	_____
___ Cigar	___ per day/month/year	_____
___ Patch/Gum	___ per day/month/year	_____
8. Do you have any family history of diabetes? \_\_\_ Yes \_\_\_ No  
 If yes, list member and current age.
9. Do you have any adverse affects from diabetes (i.e. protein in urine, neuropathy (loss of feeling), eye trouble)? \_\_\_ Yes \_\_\_ No If yes, explain: