



Trinity Life Insurance Company

7633 East 63rd Place, Suite 230

Tulsa, OK 74133

Phone: (918) 249-2438 Fax: (918) 249-2478

DIABETIC QUESTIONNAIRE – COMPLETED BY APPLICANT

NAME	FILE NUMBER	DATE
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1. (a) Height? _____ Ft. _____ In. (b) Weight? _____ Lbs. (c) Weight one year ago? _____ Lbs.

2. Date diabetes diagnosed? _____

3. Name and address of Doctor supervising your diabetic program?

NAME _____

ADDRESS _____

How long have you been under his care? _____ Date of Last Visit? _____

How often do you consult him for examination and advise? _____

Have you consulted any other doctors about diabetes in the past 3 years? YES NO

If yes, give names and addresses under 11 below or on reverse side.

4. What is your daily diet prescription? Carbohydrates _____ gms.
 Protein _____ gms.
 Fat _____ gms.

Do you measure or estimate your food portions from an exchange list? Measure? _____ Estimate _____

5. Do you take Insulin? YES NO If yes, Type? _____ Daily Dose? _____
 Do you take medication? YES NO List medication Names? _____

6. How often do you test your urine for sugar? _____ At what time of the day do you do so? _____
 What percentage of tests are positive for sugar? _____

7. How often do you have blood sugar determinations made? _____ Give results of the test made
 In the past two years, indicate whether fasting or other times.

DATE	RESULTS		DATE	RESULTS	
	Fasting	Other Times		Fasting	Other Times
1. _____	_____	_____	1. _____	_____	_____
2. _____	_____	_____	2. _____	_____	_____

8. Date you last had an electrocardiogram made? _____ An X-ray of Chest? _____
 (Give name and address of physician who made tests under number 11 below)

9. How many times have you been in diabetic coma, or had acidosis severe enough to require Hospitalization? _____
 Have you ever had insulin shock, or do you have frequent insulin reactions? _____

10. Have you ever had: Elevated Blood Pressure? YES NO Heart trouble? YES NO
 Kidney trouble? YES NO Recurrent infections? YES NO
 Other Prolonged illness? YES NO (If yes, give details under 11 below or on reverse side)

11. Use this space for additional explanations. Give complete information, including dates, names and address of attending physicians and hospitals. Use reverse side if additional space is needed.

Date: _____ SIGNATURE: _____