Manulife

DIABETIC QUESTIONNAIRE TO BE COMPLETED BY ATTENDING DOCTOR

Proposed life assured: _____ **Proposal No:** _____

NRIC No: _____ **Age:** _____ **Sex:** ☐ **Male** ☐ **Female**

We would appreciate if you could kindly complete this questionnaire.

1. a. **Date of first registration at your clinic** _____

   b. **Date diabetes was first diagnosed** _____

   c. **Date of onset and duration of his/her diabetes** _____

2. **Name and address of any other Doctors who have treated the proposed life assured for diabetes**

   _____

   _____

3. **How is the proposed life assured diabetes controlled?**

   ☐ **By Diet Control** ☐ **Oral Hypoglycemic agents** ☐ **Insulin**

Name of drugs used	Dosage	Date treatment started

4. a. **Does the proposed life assured maintain regular follow up at your clinic for his/her diabetes?** ☐ **Yes** ☐ **No**

   b. **Does the proposed life assured follow your advice regarding his/her diet control and medication?** ☐ **Yes** ☐ **No**

5. **Please record the last three urine examination results as recorded by your clinic**

	Date	Sugar	Albumin	Microscopic Examination
a.				
b.				
c.				

6. **Please provide us with the last two blood test results of the following if carried out:**

	Date	Results	Date	Results
a. Blood Glucose (Fasting)				
b. Blood Glucose (2 hrs. Postprandial)				
c. Glycohaemoglobin (HbA1c)				
d. Blood Lipids profile				
e. Others (Please specify)				

7. **Has the proposed life assured ever been hypertensive?** ☐ **Yes** ☐ **No**

   If the answer is "Yes" please state date and level of his/her highest blood pressure reading **Date:** _____ **Blood Pressure:** _____

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8. How well is his/her diabetes controlled? ☐ Very well ☐ Moderate ☐ Poor

9. Does the proposed life assured smoke cigarettes? ☐ I do not know ☐ Yes he/she smokes ☐ Non-smoker

If the answer is "Yes" please provide details

Amount smoked: _____ Duration: _____

10. Has the proposed life assured ever suffered from any of the following?

	Yes	No	
Diabetic Coma	☐	☐	Date of event : _____
Peripheral Artery Disease	☐	☐	
Diabetic Nephropathy	☐	☐	
Unexplained Proteinuria	☐	☐	Amount of protein : _____
Diabetic Retinopathy	☐	☐	Grade : _____
Coronary Artery Disease	☐	☐	Date of diagnosis : _____

11. Were any of the following carried out on this proposed life assured?

Name of test	Date of this test	Normal	Abnormal	Details of abnormal findings
Resting ECG				
Stress ECG				

12. Do you know of any other relevant factors that may assist us to assess his/her medical impairment and future diagnosis? ☐ Yes ☐ No

Please provide details if "Yes"

_____

This questionnaire has been completed by:

_____ _____

Signature of Doctor Clinic Rubber Stamp

Name : _____

Telephone No. : _____

Dated : _____

Kindly return this Questionnaire in a sealed envelope to the underwriter of our Company so as to maintain confidentiality of the information provided.

(We thank you for completing this questionnaire)

Name of Underwriter: _____ Date: _____