

<input style="width: 95%; height: 20px;" type="text"/> Last name	<input style="width: 95%; height: 20px;" type="text"/> First name
Date of birth: <input style="width: 150px; height: 20px;" type="text"/> <div style="display: flex; justify-content: space-around; font-size: small;"> Year Month Day </div>	<input style="width: 100%; height: 20px;" type="text"/> Application or Contract No.

1 What type of diabetes do you have?

- Type 1 diabetes (treated with insulin)
- Type 2 diabetes
- Gestational diabetes: Are you pregnant?
 - Yes – Due date:

Year
Month
 - No – Last delivery date:

Year
Month

2 Date of diagnosis:

Year
Month

3 Name and address of your attending physician: _____

4 a) How often do you see your attending physician? _____

b) Date of last visit:

Year
Month

5 Have you ever consulted or should you consult a specialist (endocrinologist, cardiologist, nephrologist, etc.)? Yes No
If so, specify the dates of consultations and the name and mailing address of any physicians consulted.

Name	Address	Date of consultation
_____	_____	<input style="width: 100%; height: 20px;" type="text"/> <div style="display: flex; justify-content: space-around; font-size: small;"> Year Month </div>
_____	_____	<input style="width: 100%; height: 20px;" type="text"/> <div style="display: flex; justify-content: space-around; font-size: small;"> Year Month </div>
_____	_____	<input style="width: 100%; height: 20px;" type="text"/> <div style="display: flex; justify-content: space-around; font-size: small;"> Year Month </div>

6 Type of treatment:

- Diet
- Medication (name and dosage): _____
- Insulin (name and number of units per day): _____

- 7 a) Follow-up: Monitoring at a diabetes clinic Home monitoring
 b) Do you use a blood glucose monitor? Yes No

If so, specify.

Frequency of use	Date of last reading	Results of last reading				
_____	<table border="1"> <tr> <td>Year</td> <td>Month</td> </tr> <tr> <td> _ _ _ </td> <td> _ </td> </tr> </table>	Year	Month	_ _ _	_	_____
Year	Month					
_ _ _	_					

If not, please explain.

Frequency of blood sugar testing per year	Date of last blood sugar testing	Results of last glycosylated hemoglobin (HbA1c) test				
_____	<table border="1"> <tr> <td>Year</td> <td>Month</td> </tr> <tr> <td> _ _ _ </td> <td> _ </td> </tr> </table>	Year	Month	_ _ _	_	_____
Year	Month					
_ _ _	_					

- 8 a) Have you ever suffered from:

	Yes	No	Date	Diagnosis				
Cardiac disorders	<input type="checkbox"/>	<input type="checkbox"/>	<table border="1"> <tr> <td>Year</td> <td>Month</td> </tr> <tr> <td> _ _ _ </td> <td> _ </td> </tr> </table>	Year	Month	_ _ _	_	_____
Year	Month							
_ _ _	_							
Eyesight disorder	<input type="checkbox"/>	<input type="checkbox"/>	<table border="1"> <tr> <td>Year</td> <td>Month</td> </tr> <tr> <td> _ _ _ </td> <td> _ </td> </tr> </table>	Year	Month	_ _ _	_	_____
Year	Month							
_ _ _	_							
Foot condition	<input type="checkbox"/>	<input type="checkbox"/>	<table border="1"> <tr> <td>Year</td> <td>Month</td> </tr> <tr> <td> _ _ _ </td> <td> _ </td> </tr> </table>	Year	Month	_ _ _	_	_____
Year	Month							
_ _ _	_							
Kidney disorders (including protein in urine)	<input type="checkbox"/>	<input type="checkbox"/>	<table border="1"> <tr> <td>Year</td> <td>Month</td> </tr> <tr> <td> _ _ _ </td> <td> _ </td> </tr> </table>	Year	Month	_ _ _	_	_____
Year	Month							
_ _ _	_							
Ulcers	<input type="checkbox"/>	<input type="checkbox"/>	<table border="1"> <tr> <td>Year</td> <td>Month</td> </tr> <tr> <td> _ _ _ </td> <td> _ </td> </tr> </table>	Year	Month	_ _ _	_	_____
Year	Month							
_ _ _	_							
Other: _____	<input type="checkbox"/>	<input type="checkbox"/>	<table border="1"> <tr> <td>Year</td> <td>Month</td> </tr> <tr> <td> _ _ _ </td> <td> _ </td> </tr> </table>	Year	Month	_ _ _	_	_____
Year	Month							
_ _ _	_							

- b) Have you ever suffered from high blood pressure? Yes No If so, specify.

Frequency of checks	Date of last check	Results of last check				
_____	<table border="1"> <tr> <td>Year</td> <td>Month</td> </tr> <tr> <td> _ _ _ </td> <td> _ </td> </tr> </table>	Year	Month	_ _ _	_	_____
Year	Month					
_ _ _	_					

- c) Have you ever suffered from circulatory problems? Yes No

If so, have you undergone examinations? Yes No If so, specify the name and the date of the examination.

Name of examination	Date of examination				
_____	<table border="1"> <tr> <td>Year</td> <td>Month</td> </tr> <tr> <td> _ _ _ </td> <td> _ </td> </tr> </table>	Year	Month	_ _ _	_
Year	Month				
_ _ _	_				
_____	<table border="1"> <tr> <td>Year</td> <td>Month</td> </tr> <tr> <td> _ _ _ </td> <td> _ </td> </tr> </table>	Year	Month	_ _ _	_
Year	Month				
_ _ _	_				
_____	<table border="1"> <tr> <td>Year</td> <td>Month</td> </tr> <tr> <td> _ _ _ </td> <td> _ </td> </tr> </table>	Year	Month	_ _ _	_
Year	Month				
_ _ _	_				

d) Have you ever experienced a diabetic coma? Yes No **If so, specify.**

Name of hospital	Address	Date		
_____	_____	<table border="1"> <tr> <td>Year</td> <td>Month</td> </tr> </table>	Year	Month
Year	Month			
_____	_____	<table border="1"> <tr> <td>Year</td> <td>Month</td> </tr> </table>	Year	Month
Year	Month			
_____	_____	<table border="1"> <tr> <td>Year</td> <td>Month</td> </tr> </table>	Year	Month
Year	Month			

9 Have you undergone or do you have to undergo any tests or examinations in connection with this condition? Yes No **If so, specify.**

Tests/exams	Result (if applicable)	Date		
<input type="checkbox"/> Echocardiogram	_____	<table border="1"> <tr> <td>Year</td> <td>Month</td> </tr> </table>	Year	Month
Year	Month			
<input type="checkbox"/> Electrocardiogram (ECG)	_____	<table border="1"> <tr> <td>Year</td> <td>Month</td> </tr> </table>	Year	Month
Year	Month			
<input type="checkbox"/> Treadmill test	_____	<table border="1"> <tr> <td>Year</td> <td>Month</td> </tr> </table>	Year	Month
Year	Month			
<input type="checkbox"/> Other: _____	_____	<table border="1"> <tr> <td>Year</td> <td>Month</td> </tr> </table>	Year	Month
Year	Month			

10 Have you been hospitalized as a result of this condition? Yes No **If so, specify.**

Name of hospital	Address	Date of admission		
_____	_____	<table border="1"> <tr> <td>Year</td> <td>Month</td> </tr> </table>	Year	Month
Year	Month			
_____	_____	<table border="1"> <tr> <td>Year</td> <td>Month</td> </tr> </table>	Year	Month
Year	Month			
_____	_____	<table border="1"> <tr> <td>Year</td> <td>Month</td> </tr> </table>	Year	Month
Year	Month			


11 Have you ever had to go on disability leave because of this condition? Yes No

If so, specify the start date and length of each disability period.

Start date	Length (number of weeks)		
<table border="1"> <tr> <td>Year</td> <td>Month</td> </tr> </table>	Year	Month	_____
Year	Month		
<table border="1"> <tr> <td>Year</td> <td>Month</td> </tr> </table>	Year	Month	_____
Year	Month		

I hereby acknowledge and agree that the answers to the questions in this questionnaire are true and complete.

Signed at _____ on this _____ day of _____ 20 ____ .

	
Signature of proposed insured or of legal guardian, if the proposed insured is under age 18 in Quebec or under 16 in other provinces.	Signature of witness