La Capitale

DIABETES QUESTIONNAIRE

Last name

First name

Date of birth: Year Month Day

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
		Year Month
		Year Month
		Year Month

6 Type of treatment:

☐ Diet

☐ Medication (name and dosage): _____

☐ Insulin (name and number of units per day): _____

La Capitale Civil Service Insurer Inc.
625 Jacques-Parizeau St, Quebec QC G1R 2G5

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7150 Derrycrest Drive, Mississauga ON L5W 0E5

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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
	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
	Year Month	

c) Do you use an insulin pump? ☐ Yes ☐ No

If not, do you plan to use one and buy an insulin pump? ☐ Yes ☐ No

8 a) Have you ever suffered from:

	Yes	No	Date	Diagnosis
Cardiac disorders	◯	◯	Year Month	
Eyesight disorder	◯	◯	Year Month	
Foot condition	◯	◯	Year Month	
Kidney disorders (including protein in urine)	◯	◯	Year Month	
Ulcers	◯	◯	Year Month	
Other: _____	◯	◯	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
	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
	Year Month
	Year Month
	Year Month

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

Name of hospital	Address	Date
		Year Month
		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
☐ Echocardiogram		Year Month
☐ Electrocardiogram (ECG)		Year Month
☐ Treadmill test		Year Month
☐ Other:		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
		Year Month
		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)
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 _____ .

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

X _____
Signature of witness

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