SONS OF NORWAY
1455 West Lake Street
Minneapolis, MN 55408-2666
Phone (612) 827-3611
Toll Free (800) 945-8851
Fax (612) 827-0658
www.sonsofnorway.com

Diabetic Questionnaire

Name of Proposed Insured: _____ Date of Birth: _____

1. Height: _____ Weight: _____ Weight one year ago: _____

2. Date Diabetes first diagnosed: _____

⇨ Name and address of physician making the diagnosis:

_____

3. Name and address of physician giving treatment or medical supervision:

_____

4. Was electrocardiogram made? ❑ YES ❑ NO Date: _____ By whom? _____

⇨ Was EKG normal? ❑ YES ❑ NO Date: _____ By whom? _____

5. Was chest X-ray made? ❑ YES ❑ NO Date: _____ By whom? _____

6. Treatment used:

- **DIET ONLY** ❑ YES ❑ NO
  - ⇨ Is diet weighed? ❑ YES ❑ NO
  - Name: _____ Number of units: _____
- **ORAL MEDICATION** ❑ YES ❑ NO
  - ⇨ Name: _____
- **INSULIN** ❑ YES ❑ NO

7. Do you ever stop the oral medication, insulin or go off diet? ❑ YES ❑ NO

⇨ If "yes," please explain: _____

8. Is urine regularly tested for sugar? ❑ YES ❑ NO

⇨ Are results usually: ❑ NEGATIVE ❑ TRACE ❑ MORE THAN TRACE

Date of last test: _____ Results: _____

9. Have you had blood sugar tests? ❑ YES ❑ NO

⇨ Date of last test: _____ Results: _____

10. Have you been unable to work due to complications of your diabetes? ❑ YES ❑ NO

⇨ If "yes," please explain: _____

11. Do you regularly drink alcoholic beverages? ❑ YES ❑ NO

⇨ What amount? _____ How often? _____

Diabetic Questionnaire (continued)

Give details to any "Yes" answers for the following in the space provided below:

1. Have you been treated for:

- **A.** Insulin reactions? ❑ YES ❑ NO
- **B.** Diabetic coma? ❑ YES ❑ NO

2. Have you ever had:

- **A.** Eye trouble? ❑ YES ❑ NO
- **B.** Heart trouble? ❑ YES ❑ NO
- **C.** High blood pressure? ❑ YES ❑ NO
- **D.** Kidney trouble (albuminuria)? ❑ YES ❑ NO
- **E.** Poor circulation of toes, feet or legs? ❑ YES ❑ NO
- **F.** Recurring or prolonged illness? ❑ YES ❑ NO

NUMBER	DATE	PHYSICIAN'S COMPLETE NAME & MAILING ADDRESS AND/OR HOSPITAL

I hereby represent that all of the above statements and answers to all the above questions are complete and true.

_____ _____

Signature of Proposed Insured *Date*