Attending physician's diabetic questionnaire

Policy no.	Evidence no. (for H.O. use only) E#

Proposed insured's first name	Middle initial	Last name	Date of birth (dd-mm-yyyy)
			– –

1. Period of time under your observation as a patient. From Date (mm-yyyy) – to Date (mm-yyyy) –
2. Date of diagnosis Date (mm-yyyy) –
3. a) Insulin: Type and units per day now

   Maximum daily amount in the past

   b) Oral hypoglycemic agent: Give type and dosage:
4. Diet: Carbohydrate Fat Protein
5. Does the patient report regularly for examination and advice? ☐ Yes ☐ No

   How often? Date of last visit? Date (dd-mm-yyyy) – –
6. Does the patient follow advice consistently? ☐ Yes ☐ No
7.

Blood Test	Date (dd-mm-yyyy)	Results
Fasting blood sugar	– –	
	– –	
2 Hour p.c. blood sugar	– –	
	– –	
HbA1C	– –	
	– –	

8. Have there been any episodes of loss of control of the diabetes, coma or insulin reaction? ☐ Yes ☐ No

   If '**yes**', give dates, duration, severity and cause in the box below.

9. Does patient use alcoholic beverages? ☐ Yes ☐ No

   If '**yes**', state type used, amount consumed, frequency of use, any excess, etc., in the box below.

Please send only one copy – original or fax toll-free to 1-866-487-4745.

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Evidence no. (for H.O. use only)
E#

Attending physician's diabetic questionnaire (continued)

10. Has the patient **ever** shown any evidence of the following diabetic complications?

cerebro-vascular	☐ Yes	☐ No	kidney disease	☐ Yes	☐ No
coronary arteries	☐ Yes	☐ No	peripheral vessels	☐ Yes	☐ No
eye grounds	☐ Yes	☐ No			

If '**yes**' to any of the above, give details, including blood pressure readings and dates in the box below.

11. Has an electrocardiogram been taken? ☐ Yes ☐ No If '**yes**', give dates, by whom taken and results in the box below.

Note: Please forward all tracings. They will be returned promptly.

12. Has patient shown any evidence of other significant illness or injury? ☐ Yes ☐ No If '**yes**', give details in the box below.

Location signed (city)	Location signed (province)	Date (dd-mm-yyyy)	Signature of attending physician
		– –	X

Please only submit one copy of this form. Fax toll-free to 1-866-487-4745 or send to:

Sun Life Assurance Company of Canada
227 King Street South
PO Box 1601 Stn Waterloo
Waterloo, ON N2J 4C5

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