

Please print or type all information

Proposed insured _____ Date of birth _____ Identification Number _____

1. When was diabetes first diagnosed? _____ Blood Sugar: _____
2. Under your care from _____ (date) to _____ (date)
3. Is diabetes difficult to control? No Yes
If yes, explain: _____
4. Is oral medication prescribed? No Yes
a. Kind? _____ b. Dosage? _____
5. Is insulin employed in treatment? No Yes
a. Type(s)? _____ b. Total Units Per Day: _____
6. Does current treatment differ from that employed two years ago? No Yes
If yes, how? _____
7. Date of last consultation _____ (date). At that time, what were:
a. Height? _____ b. Weight? _____ c. Blood pressure? _____ / _____
d. Highest blood pressure was _____ / _____ on _____ (date).
e. Has blood pressure ever required treatment? No Yes
If yes: Medication and Dosage _____
Treatment Dates _____ (date) to _____ (date)
f. How often are tests made of: Blood Sugar? _____ HbA1c? _____ Urine? _____
g. Most recent blood sugar was _____ on _____ (date). Fasting Other
h. Most recent glycohemoglobin was _____ on _____ (date). Fasting Other
8. Is there any evidence or record of: Heart Disease? Retinitis? ECG Changes?
 Vascular Disease? Renal Disease?

Please give details of positive findings: _____

9. Have there been any hospitalizations due to Diabetic Complications? _____
Dates and name/address of hospital(s)? _____
10. For what other diseases has patient been treated? _____

11. Other physicians consulted? _____

12. Comments: _____

Dated: _____ Signed _____ M.D. Identification No. _____

Proposed insured_____
Date of birth_____
Identification Number

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1. Please indicate diagnosis or nature of the psychiatric disorder for which treatment was sought or recommended (Use DSM III terminology and code, if possible).
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2. Please indicate to the best of your knowledge
- a) Date of onset of symptoms and duration _____
- b) Date of exacerbation of symptoms leading to treatment _____
- c) Is there any identifiable stress which you feel is causally related to the onset of symptoms?
If so please specify _____
- d) Date therapy with you began _____ Frequency of visits _____ Date of last visit _____
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3. At the time your treatment of the patient commenced how severely impaired was his adaptation or ability to function?
- Would you characterize the problem as
- a) Acute situational reaction in a basically healthy personality
- b) A personality or emotional disorder with fair adaption in most areas
- c) A personality or emotional disorder with less adequate adaption in some areas
- d) A personality or emotional disorder with poor adaption in some areas or difficulty in many areas
- e) Severe emotional disorder with poor or no adaption in one or more crucial areas of functioning
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4. At the present time or as of your last contact with the patient how would you classify his or her status according to the above criteria?
- Category a b c d e | Improved? yes no Recovered? yes no
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5. Have any sedative or psychotropic drugs been prescribed? If yes, give names, dosages and duration of use.
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6. Has there been any hospitalization? ECT? time lost from work because of a psychiatric illness?
If so when? and for how long?
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7. Has suicide ever been attempted or threatened? If yes, when and how?
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8. Is there any history of excessive use of alcohol or drug abuse? If yes, please describe.
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9. To your knowledge has the patient had any somatic or psychophysiological symptoms related to the psychiatric problem referred to in (1) above? If so, please describe.
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10. Are you aware of any other medical problems or other physicians consulted? If so, may we please have details?
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Dated: _____, _____ Signed _____ M.D. Identification No. _____