



DIABETES QUESTIONNAIRE

(Please complete this form for each person listed on the application who has diabetes.)

Patient's Name	Applicant's Name (if different from patient)
----------------	--

Please answer the following questions about you or your dependent's diabetes. If you are not sure about an answer, your physician will be able to provide you with the necessary information, or may complete this questionnaire on your behalf. Your complete and honest answers will help to determine eligibility for coverage. Incomplete or inaccurate information on this form may lead to denial of claims and/or cancellation of coverage, as explained on your application and health statement.

1. How long has patient had diabetes? _____

2. Please give the most recent blood sugar readings and dates during the last 2 years:

Mo. _____	Yr. _____	Reading _____	Mo. _____	Yr. _____	Reading _____
Mo. _____	Yr. _____	Reading _____	Mo. _____	Yr. _____	Reading _____
Mo. _____	Yr. _____	Reading _____	Mo. _____	Yr. _____	Reading _____

3. Please give the name, strength, and dosage of each prescription drug or injection taken for diabetes during the past three years:

Give name, strength, dosage, and length of time on current medication: _____

4. Does the patient take any other prescription drug(s) for treatment of other medical conditions? Yes No

If Yes, please give the name of the drug, the dosage, strength, and the condition for which it is being taken: _____

5. Height: _____ Weight: _____ Has there been any marked change in patient's weight during the past two years? Yes No

Amount gained _____ lbs. Amount lost _____ lbs.

6. Have there been any problems with the eyes, kidneys, extremities or skin? Yes No

If Yes, list condition, date diagnosed, and treatment, including dates: _____

Physician's name and address: _____

— Agreement —

I understand this questionnaire is attached to and becomes part of my application and health statement. I understand conditions of my application for health coverage previously agreed to by me on my application and health statement are applicable to my answers to this questionnaire.

BLUE CROSS AND BLUE SHIELD OF GEORGIA is authorized to present a copy of this signed Agreement to any hospital, physician, other provider of care in order to obtain any medical information regarding myself or any listed family member.

Patient's Signature Date
(if different from applicant)

Physician's Signature Date
(needed only if the physician has filled out this form on behalf of the patient)

Applicant's Signature Date