Diabetes Questionnaire

INTERNATIONAL MEDICAL GROUP

International Medical Group®, Inc.
P.O. Box 88509
Indianapolis, Indiana 46208-0509 USA
Phone: 800.628.4664 (In US)
317.655.4500(Outside US)
Fax: 317.655.4505
Email: insurance@imglobal.com
www.imglobal.com

Please print

Name:		
Date of Birth:		
1. When were you told you had diabetes?		
2. Type of diabetes?		
3. Name, address and telephone number of present attending physician(s):		
4. Frequency of visits to a physician:	Date of last visit:	
5. Frequency of blood sugars:	Date and result of last blood sugar:	Method used:
6. Do you test your urine for sugar?	How often?	Method used:
7. Treatment Diet: Insulin (type and dosage schedule): Oral medication (type and dosage of all):		
8. Has treatment changed during the last five years? ☐ Yes ☐ No If yes, describe the changes		

9. Have you ever had the following? Please provide dates, names, addresses and telephone number of attending physician(s).

Diabetic coma?	☐ Yes ☐ No	Eye trouble?	☐ Yes ☐ No
Insulin shock?	☐ Yes ☐ No	High blood pressure?	☐ Yes ☐ No
Heart disease?	☐ Yes ☐ No	Nerve disorder?	☐ Yes ☐ No
Kidney disease?	☐ Yes ☐ No	Any other complication?	☐ Yes ☐ No

10. Do other members of your family have diabetes? ☐ Yes ☐ No
If yes, whom?

Signature_____ Date_____