# QUESTIONNAIRE – DIABETES

**SSQ, Life Insurance Company Inc.**
1225 Saint-Charles Street West, Suite 200, Longueuil, Quebec J4K 0B9

| GENERAL INFORMATION | | |
|---|---|---|
| NAME | DATE OF BIRTH | CONTRACT NUMBER |
| | | |

## I – MEDICAL HISTORY

1. Medical diagnosis: ☐ Non Insulo-Dependant Diabetes Mellitus ☐ Juvenile Diabetes
   ☐ Insulin-Dependant Diabetes Mellitus ☐ Gestational Diabetes
   ☐ Other (specify): _____
   Date of diagnosis: _____
2. Episode of: ☐ Diabetic coma ☐ Reaction to insulin ☐ None
   Date: _____ Frequency: _____
3. Other medical conditions: ☐ Eye disorders ☐ Heart and cardiovascular disorders
   ☐ High Blood Pressure ☐ Albumin/protein in urine
   ☐ Kidney disorders ☐ Other (specify): _____
4. Glucometer : ☐ No ☐ Yes Frequency: _____ Results: _____
5. Current weight: _____ Last year: _____ Two (2) years ago: _____

## II – TREATMENTS

1. Medication prescribed : ☐ Diet ☐ Oral medication ☐ Insulin
   Name and dosage: _____
2. Currently under medication: ☐ No ☐ Yes (specify): _____
3. Hospitalization for diabetes: ☐ No ☐ Yes (specify): _____ Date: _____
4. Hospitalization for related condition : ☐ No ☐ Yes (specify): _____ Date: _____
5. Visit to be scheduled: ☐ No ☐ Yes (specify): _____ Date: _____

## III – DISABILITY

1. Leave of absence: ☐ No ☐ Yes Date: _____ Duration: _____
2. Disability period: ☐ No ☐ Yes Date: _____ Duration: _____
3. Limitation/after-effects: ☐ No ☐ Yes (specify): _____

## IV – ATTENDING PHYSICIAN

1. Name and address of physician who has your complete file: _____
   _____
2. Date of last visit: _____ Results: _____

## V – ADDITIONAL INFORMATION CONCERNING YOUR CONDITION

_____
_____

I acknowledge having read and understood all the questions above and having given the correct answers. In addition, I consent to having them serve as the basis of the insurance contract requested.

| Signature of witness | Date | Signature of the person to be insured or to be co-insured. If under age 18, signature of father or mother required. |
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