Risk Assessment– Diabetes

Agent Name:	
Address:	
Email:	
Phone:	
Applicant Name:	
Date Of Birth:	
Sex:	**Male** **Female**
Height/Weight:	
Occupation:	
Death Benefit:	
Type of Product:	**Term** **UL** **Whole Life** **2nd To Die**
Has Client EVER Used Tobacco? **YES** **NO**	**Date of Last Use:**
Specify All Types of Nicotine Used:	**Cigarettes** **Cigar** **Pipe** **Other:**
Has Client Ever Been Hospitalized for Diabetes? **YES** **NO**	**Dates & Duration of Each Stay:**
Date of Diagnosis:	
When Was A Doctor Last Seen?	
Does client take medication? **YES** **NO**	**List All RX & Dosage:**

When did client last see Dr.?	
How often does client see Dr.?	
Is an A1C test done on Each visit? **YES NO**	**Last A1C Level:** **Date:**
Does client know current sugar level? **YES NO**	**Current Level:** **Date of Last Reading:**
Any Neurological Symptoms Such as loss of feeling in feet?	**YES NO**
Any Protein in the Urine?	**YES NO**
Last Glucose Test:	**Date of Reading:** **Results:**
Has Client had Kidney Prob-lems? **YES NO**	**Details:**
Any Problem with Eyes? **YES NO**	**Details of Treatment:**
Any High Blood Pressure? **YES NO**	**Date & Details:**
Any "Heart Trouble" **YES NO**	**If "YES" please also complete Heart Questionnaire**
Family History of Diabetes: (father, mother, siblings)	**Age at Onset:** **Age and Cause of Death:**

Additional Comments:

This Questionnaire Must Accompany Your Formal Application.

FSA Preliminary Assessment:___________________________