



**DIABETES QUESTIONNAIRE**  
(complete all questions)

Name of primary applicant: \_\_\_\_\_ ID/SSN: \_\_\_\_\_

Name of person treated: \_\_\_\_\_ Relationship to applicant: \_\_\_\_\_

1. Date diagnosed or date of first symptoms: \_\_\_\_\_ Blood sugar reading at that time? \_\_\_\_\_

2. Please indicate type of treatment: \_\_\_\_\_ Diet \_\_\_\_\_ Oral medication \_\_\_\_\_ Insulin

Are you compliant with dietary restrictions and recommended medications? Yes \_\_\_\_\_ No \_\_\_\_\_

If no, explain: \_\_\_\_\_

Name of Medication	Dosage:	Frequency (i.e., daily, weekly)

3. Have you ever been hospitalized for diabetes or any related conditions? Yes \_\_\_ No \_\_\_ If yes, provide complete details regarding dates of stay and treatment received: \_\_\_\_\_

4. How often does your doctor check blood sugar levels \_\_\_\_\_

How frequently do *you* test your blood sugar? \_\_\_\_\_ Usual reading? \_\_\_\_\_

5. Please provide **last 4 fasting blood sugar readings or Hgb A1C readings from your doctor and date of tests:**

\_\_\_\_\_

\_\_\_\_\_

6. Any history of:	<b>(Circle one)</b>	
Kidney disease	yes	no
Recurrent infections	yes	no
Circulatory disorders	yes	no
Leg or foot ulcers	yes	no
Insulin reactions	yes	no
Vision problems (Retinopathy)	yes	no
Decreased feeling, numbness or tingling in extremities	yes	no

Please explain any "yes" answers: \_\_\_\_\_

7. What is your current height? \_\_\_\_\_ Weight? \_\_\_\_\_

8. Name and address of treating physician: \_\_\_\_\_

9. Any other comments? \_\_\_\_\_

All of the above statements are true, complete and correctly recorded to the best of my knowledge. I understand Anthem Blue Cross and Blue Shield will rely on these statements when determining eligibility.

Signature of person treated (or parent/guardian if under 18) \_\_\_\_\_

Date \_\_\_\_\_

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