



INTERNATIONAL MEDICAL GROUP

Diabetes Questionnaire

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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? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No Eye trouble? <input type="checkbox"/> Yes <input type="checkbox"/> No
Insulin shock? <input type="checkbox"/> Yes <input type="checkbox"/> No High blood pressure? <input type="checkbox"/> Yes <input type="checkbox"/> No
Heart disease? <input type="checkbox"/> Yes <input type="checkbox"/> No Nerve disorder? <input type="checkbox"/> Yes <input type="checkbox"/> No
Kidney disease? <input type="checkbox"/> Yes <input type="checkbox"/> No Any other complication? <input type="checkbox"/> Yes <input type="checkbox"/> No
10. Do other members of your family have diabetes? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, whom?

Signature _____ Date _____