

Diabetic Questionnaire

For Completion by the Attending Physician.

Name of Applicant: _____ Date of Birth: _____

1. When was the diabetes diagnosed?

2. What treatment is currently being prescribed?

i. Diet only (please describe nature of diet)

ii. Oral hypoglycaemics (please state drug/s and dosage/s)

iii. Insulin (please state type/s and dosage/s)

3. To your knowledge does your patient control his/her condition? _____

- A. Poorly
- B. Moderately well
- C. Well

4. Please give dates and results of glycosylated haemoglobin (HbA1c) and blood glucose levels over the past 12 months.

**5. Has your patient ever suffered from any episodes of hypoglycaemia, ketoacidosis or diabetic coma?
If "yes" please provide details.**

Yes No

Is there evidence of complications of diabetes present?

Yes No

If "yes" please provide details:

i. Retinopathy

ii. Nephropathy

iii. Neuropathy

iv. Vascular disease

v. Ischaemic heart disease

vi. Microalbuminuria

7. Are there any other adverse features present that may accelerate the onset of complications, eg family history of renal or cardiovascular disease, cigarette smoking, alcohol consumption, unwillingness to follow medical advice?

Yes No

If "yes" please provide details.

10. Has the patient ever been required time off work due to this condition? Yes No

If "yes" please provide details including when and for how long.

Signature of Attending Physician

Date