# BAF INSURANCE COMPANY (CAYMAN) LIMITED
# DIABETES AND OTHER GLUCOSE METABOLISM DISORDERS QUESTIONNAIRE

To be completed by the treating physician
(PLEASE USE BLOCK LETTERS)

## ① PATIENT'S INFORMATION

Name: _____
Last First M.I.

Date of birth: ____/____/____
Month Day Year

## ② DIAGNOSIS

Please provide details about when the condition was diagnosed

| Date of first visit | Details |
|---|---|
| ____/____/____ Month Day Year | Symptoms: _____ |
| Type of diabetes _____ | Diagnosis: _____ |

Is the patient under treatment? If "Yes", please provide details. ❍ Yes ❍ No

| Diet | Insulin |
|---|---|
| | |
| **Oral medication (name/dosage)** | **Combination (explain)** |
| | |

Has the patient had any of the following complications? If "Yes", please explain.

| Condition | | Date of first symptom | Severity | Frequency |
|---|---|---|---|---|
| Retinopathy | ❍ Yes ❍ No | ____/____/____ Month Day Year | | |
| Neuropathy | ❍ Yes ❍ No | ____/____/____ Month Day Year | | |
| Nephropathy | ❍ Yes ❍ No | ____/____/____ Month Day Year | | |
| Intermittent claudication | ❍ Yes ❍ No | ____/____/____ Month Day Year | | |
| Skin disorders | ❍ Yes ❍ No | ____/____/____ Month Day Year | | |
| Heart disease | ❍ Yes ❍ No | ____/____/____ Month Day Year | | |
| Other complications | ❍ Yes ❍ No | ____/____/____ Month Day Year | | |
| Hospital admissions | ❍ Yes ❍ No | ____/____/____ Month Day Year | | |

Please provide the following information

| Date | Height | Weight |
|---|---|---|
| ____/____/____ Month Day Year | _____ ❍M ❍Ft | _____ ❍Kg ❍Lb |

Values of blood test results performed within the past 6 months

| Fasting glucose | Glyco hemoglobin | Total cholesterol | Triglycerides |
|---|---|---|---|
| LDL | HDL | Ratio | Creatinine |

Specimen test results performed within the past 6 months

| Urine | Blood | Sugar | Albumin |
|---|---|---|---|

Please continue on next page

Has the patient undergone any of the following studies? If "Yes", please explain. (PLEASE INCLUDE REPORTS)

| Study | | Date | Result |
|---|---|---|---|
| Creatinine clearance | ❍ Yes ❍ No | / / Month Day Year | |
| 24-hour proteinuria | ❍ Yes ❍ No | / / Month Day Year | |
| Glucose tolerance | ❍ Yes ❍ No | / / Month Day Year | |
| Other _____ | ❍ Yes ❍ No | / / Month Day Year | |

| History of smoking | | Other comments |
|---|---|---|
| Amount per day | Number of years | |
| | | |

Have you referred the patient to another specialist or hospital, or know of treatment rendered elsewhere? ❍ Yes ❍ No
If "Yes", please the information requested below.

Physician's name: _____ (Last First M.I.) Telephone number: ( )

Outpatient treatment: _____

Hospital: _____ Telephone number: ( )

Hospital treatment: _____

## ③ TREATING PHYSICIAN'S INFORMATION

Name: _____ (Last First M.I.)

Address: _____

Telephone number: ( ) Fax number: ( ) Email:

| Date | Signature |
|---|---|
| / / Month Day Year | |