Punjab Life
Insurance Company Limited

PUNJAB LIFE INSURANCE COMPANY LIMITED (PLIC)
DIABETES QUESTIONNAIRE (DQ)

- To be filled by Attending Physician. (**Subject Form will not be accepted without a doctor's stamp**)
- Attach a valid and clear copy of the Patient's/Member's CNIC

Client Information:			
Name		CNIC No.	
Date of Birth	____ / ____ / _____	Policy/Proposal No. (if any)	
Height (Feet/Inches)		Weight (Kgs/Lbs.)	

Doctor Information:	
Name	
Address	

Please check appropriate answers and, where applicable, give details.	
Diagnosis:	
Date of Diagnosis:	____ / ____ / _____
Last Consultation:	____ / ____ / _____

Blood Pressure	_____ / _____ ☐ Treated	Date: ____ / ____ / _____

Check-up Findings (Last Results)	**Result**	**Date**	**Result**	**Date**
Blood Glucose - Fasting				
Blood Glucose - 2 Hrs Post Prandial				
Glycohaemoglobin HbA1c				
Glycosuria - Fasting				
Glycosuria - Post Prandial				
Proteinuria				
Acetonuria				

Blood glucose in excess of 15.4 mmol/l (279 mg%) in the last 6 months?	☐ Yes ☐ No
Under medical supervision? (If yes, since)	☐ Yes ☐ No

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Diabetes under control? (If yes, since)	☐ Yes ☐ No
If diabetes not currently insulin dependent (Type 2), is insulin likely to be needed in the future?	☐ Yes ☐ No
History of recurrent ketoacidosis, keto-acidotic or hyperosmolar non-ketotic coma? How often? Last?	☐ Yes ☐ No
Smoker? Cigarettes per day:	☐ Yes ☐ No

Therapy	Yes	No	Description	Dosage	Since
Oral Antidiabetics					
Insulin					
Other Medication(s)					

ECG			Normal*		Abnormal*	
At Rest						
Exercise						

***Important: Please describe abnormal findings precisely and, if possible, attach the last ECG(s) as well as results of glucose tolerance tests.**

Complications	Yes	No	Date(s)
Diabetic Nephropathy			
Unexplained Proteinuria			
Diabetic Cataract			
Retinopathy			
Polyneuropathy			
Peripheral Artery Disease			
Coronary Heart Disease			
Cerebrovascular Disease			
Peripheral Artery Disease — Details:			

Coronary artery, cerebrovascular or peripheral artery disease before age 60 in family history	Father	Mother	Siblings	Grade

Signature & Stamp of Attending Physician:	
Place of Signing:	**Date:**

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