

MAS, FREEPOST 884, PO Box 13042, Johnsonville, Wellington.
Phone 0800 800 627. Facsimile (04) 477 0109.

Diabetes/abnormal blood sugar questionnaire

i) Please tick the appropriate condition	<input type="checkbox"/> Diabetes – go to ii below <input type="checkbox"/> Abnormal blood sugar level – go to iii below																					
ii) Please confirm type of diabetes	<input type="checkbox"/> Type 1 – Insulin dependent (IDDM) <input type="checkbox"/> Type 2 – Diet controlled, oral medication (NIDDM) <input type="checkbox"/> Gestational																					
iii) When was your condition first diagnosed?	<div style="border: 1px solid black; padding: 2px; display: inline-block;"> D D / M M / Y Y </div>																					
iv) Please advise the date and result of last blood test readings for the following:	<p>HbA1c (Glycosylated Haemoglobin) level: Result of last blood test <div style="border: 1px solid black; height: 20px; width: 100%;"></div> </p> <p>Date of last blood test <div style="border: 1px solid black; padding: 2px; display: inline-block;">D D / M M / Y Y</div></p> <p>Fasting blood glucose level: Result of last blood test <div style="border: 1px solid black; height: 20px; width: 100%;"></div> </p> <p>Date of last blood test <div style="border: 1px solid black; padding: 2px; display: inline-block;">D D / M M / Y Y</div></p>																					
v) As a result of your condition, have you ever had any of the following:	<table border="0"> <tr> <td>High blood pressure</td> <td><input type="checkbox"/> Yes*</td> <td><input type="checkbox"/> No</td> </tr> <tr> <td>High cholesterol</td> <td><input type="checkbox"/> Yes*</td> <td><input type="checkbox"/> No</td> </tr> <tr> <td>Eye problems</td> <td><input type="checkbox"/> Yes*</td> <td><input type="checkbox"/> No</td> </tr> <tr> <td>Kidney problems</td> <td><input type="checkbox"/> Yes*</td> <td><input type="checkbox"/> No</td> </tr> <tr> <td>Heart problems</td> <td><input type="checkbox"/> Yes*</td> <td><input type="checkbox"/> No</td> </tr> <tr> <td>Numbness or tingling in your legs or feet</td> <td><input type="checkbox"/> Yes*</td> <td><input type="checkbox"/> No</td> </tr> <tr> <td>Diabetic or insulin coma</td> <td><input type="checkbox"/> Yes*</td> <td><input type="checkbox"/> No</td> </tr> </table> <p><i>* If yes, please provide dates and further details</i></p> <div style="border: 1px solid black; height: 100px; width: 100%;"></div>	High blood pressure	<input type="checkbox"/> Yes*	<input type="checkbox"/> No	High cholesterol	<input type="checkbox"/> Yes*	<input type="checkbox"/> No	Eye problems	<input type="checkbox"/> Yes*	<input type="checkbox"/> No	Kidney problems	<input type="checkbox"/> Yes*	<input type="checkbox"/> No	Heart problems	<input type="checkbox"/> Yes*	<input type="checkbox"/> No	Numbness or tingling in your legs or feet	<input type="checkbox"/> Yes*	<input type="checkbox"/> No	Diabetic or insulin coma	<input type="checkbox"/> Yes*	<input type="checkbox"/> No
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I acknowledge that the answers I have provided above are true and complete and form part of my application under policy

Member Name ☐

(*Please type your name and tick the check box to verify the above information)