

PLEASE ASSIST US IN FILING YOUR INSURANCE CLAIM BY ANSWERING EACH QUESTION TO THE BEST OF YOUR ABILITY.

HEALTH QUESTIONNAIRE – Section 1 for New AND Current Insulin Pump Users

Please complete:

Name:		Phone number:	
Height:	Weight:	Age diagnosed with diabetes:	
Are you pregnant: <input type="checkbox"/> YES <input type="checkbox"/> NO		Are you planning a pregnancy: <input type="checkbox"/> YES <input type="checkbox"/> NO	
Number of years on insulin:	Type of insulin used:		
Number of injections per day: to	Number of times blood sugar checked per day: to	Range of blood sugars: Low High	
Last HbA1c test:	Result:		
C-peptide (Medicare only):			Date:
In the past 2 years, have you had any insulin reactions that required assistance from anyone or hospitalization? <input type="checkbox"/> YES <input type="checkbox"/> NO			

Diagnosis/Complications:

Diabetes type: <input type="checkbox"/> Type 1 <input type="checkbox"/> Type 2	Can you sense when your blood sugar is low? <input type="checkbox"/> YES <input type="checkbox"/> NO	
Have you ever had low blood sugar in the night while sleeping? <input type="checkbox"/> YES <input type="checkbox"/> NO	Do you wake up in the morning with blood sugar over 200 (dawn phenomenon)? <input type="checkbox"/> YES <input type="checkbox"/> NO	
Do you have any secondary problems associated with diabetes? (Please check all that apply.)		
Eye disease/retinopathy: <input type="checkbox"/> YES <input type="checkbox"/> NO	Have you required laser surgery: <input type="checkbox"/> YES <input type="checkbox"/> NO	How many:
Kidney problem/nephropathy: <input type="checkbox"/> YES <input type="checkbox"/> NO	On dialysis: <input type="checkbox"/> YES <input type="checkbox"/> NO	Kidney transplant: <input type="checkbox"/> YES <input type="checkbox"/> NO
Numbness/tingling in hands or feet/peripheral neuropathy: <input type="checkbox"/> YES <input type="checkbox"/> NO		Hand or foot amputation: <input type="checkbox"/> YES <input type="checkbox"/> NO
Delayed digestion/gastroparesis: <input type="checkbox"/> YES <input type="checkbox"/> NO	Heart attack: <input type="checkbox"/> YES <input type="checkbox"/> NO	Stroke: <input type="checkbox"/> YES <input type="checkbox"/> NO
Thyroid condition: <input type="checkbox"/> YES <input type="checkbox"/> NO	Other:	

HEALTH QUESTIONNAIRE – Section 2 for Current Insulin Pump Users ONLY

Insulin Pump Model:	Serial Number:
Number of times you check your blood sugar per day: to	Number of injections prior to insulin pump use per day: to
Please explain why you would like to upgrade your insulin pump:	
Have you had a change in physical condition since beginning insulin pump therapy that a new insulin pump will address? Please explain:	

Mail or fax form to:

MEDTRONIC DIABETES

18000 Devonshire Street, Northridge, CA 91325-1219

Fax: 1-800-433-9867

Attn: Insulin Pump Therapy Consultants