OMB Control No. 2900-0324
Respondent Burden: 45 Mins.

Department of Veterans Affairs

SUPPLEMENTAL PHYSICAL EXAMINATION REPORT (DIABETES - PHYSICIAN'S REPORT)

PRIVACY ACT INFORMATION: This report is authorized by law (38 CFR 8.8, 8.9, and 8.22). The information is required to help us make a decision on the veteran's claim for the insurance benefits under consideration. Responses may be disclosed outside VA only if the disclosure is authorized by the Privacy Act, including the routine uses identified in the VA system of records, 36VA00, Veterans and Armed Forces Personnel U.S. Government Life Insurance Records - VA, published in the Federal Register.

RESPONDENT BURDEN: VA may not conduct or sponsor, and respondent is not required to respond to this collection of information unless it displays a valid OMB Control Number. Public reporting burden for this collection of information is estimated to average 45 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have comments regarding this burden estimate or any other aspect of this collection of information, call 1-800-827-1000 for mailing information on where to send your comments.

1. NAME OF APPLICANT *(Type or print)*	2. INSURANCE FILE NUMBER

NOTICE TO APPLICANT

Any examinations required in connection with V, RS, W, RH or K insurance or in connection with reinstatement or change of plan of "J" insurance may be made by medical officers in active service or physicians of the U.S. Public Health Service, for those entitled, or may be made free of charge by a physician of the VA Regional Office or Medical Center. The examination may also be made at the applicant's own expense by a physician duly licensed for practice of medicine by a State, Territory or Possession of the United States, or District of Columbia, who is not related to the applicant, by blood or marriage, associated with his/her business, or financially interested in the granting of this insurance. Any medical examination required in connection with the issuance of the Total Disability Income Provision to "J" insurance must be made at the applicant's own expense.

NOTICE TO PHYSICIAN

Please furnish all pertinent information. If more space is needed, you may use the reverse of this form. The completed form should be sent to the office checked below. Please do not return it to the applicant. Thank you.

RETURN TO:

Department of Veterans Affairs
Regional Office and Insurance Center
P.O. Box 7208
Philadelphia, PA 19101

3. REASON APPLICANT CONSULTED PHYSICIAN	4. IS APPLICANT RECEIVING TREATMENT OR UNDER MEDICAL SUPERVISION NOW? ☐ YES ☐ NO	5. DATE FIRST TREATMENT WAS INSTITUTED

6. DATE DIABETES FIRST DIAGNOSED *(Month and year)*	7. NAME OF PHYSICIAN DIAGNOSING DIABETES	8. ADDRESS OF PHYSICIAN *(City and State)*

9. DRUGS AND/OR DIET USED IN TREATMENT	10. IS TREATMENT REGIME STRICTLY FOLLOWED? ☐ YES ☐ NO

11. DETAILS REGARDING HEIGHT OF BLOOD SUGAR BEFORE AND DURING TREATMENT

12. HAS APPLICANT EVER HAD HISTORY OF DIABETIC COMA? ☐ YES ☐ NO *(If "Yes," give dates)*	13. HAS APPLICANT EVER HAD HISTORY OF INSULIN SHOCK? ☐ YES ☐ NO *(If "Yes," give dates)*

ITEM	YES	NO	ITEM	YES	NO
INFECTIONS *(Bolts, etc.)*			HIGH BLOOD		
EYE TROUBLE			KIDNEY TROUBLE		
HEART TROUBLE					

15A. NUMBER OF TIMES APPLICANT VISITED YOU IN PAST YEAR	16A. IS URINE SUGAR FREE? NOW? ☐ YES ☐ NO ALWAYS? ☐ YES ☐ NO
15B. DATE OF LAST VISIT	16B. DATE OF LAST TEST

17. RESULTS OF CURRENT EKG

18. REPORT OF CURRENT CHEST X-RAY

19. RESULTS OF CURRENT GLUCOSE TOLERANCE TEST

DATE	BLOOD SUGAR		URINE SPEC. GRAVITY	URINE ALBUMIN	URINE SUGAR	MICROSCOPIC
	FASTING	MG%				
	1/2 HOUR	MG%				
	1 HOUR	MG%				
	2 HOURS	MG%				

20. REPORT OF ANY POST PRANDIAL OR OTHER BLOOD SUGAR TESTS

21. NAME OF EXAMINING PHYSICIAN *(Type or print)*	22. DATE EXAMINED	23. STATE IN WHICH LICENSED TO PRACTICE

24. SIGNATURE OF PHYSICIAN *(Do no print)*	25. ADDRESS OF PHYSICIAN *(City, county, State and ZIP Code)*