

MEDICAL HISTORY QUESTIONNAIRE: SLEEP APNEA

Client Name: _____ Date: _____

Gender: Male Female Height: _____ Weight: _____

Tobacco Usage:

- Never
 Former Date Stopped: _____
 Current Type: _____

Coverage Information:

- Type: Term UL IUL
 WL VUL Survivorship

Face Amount: _____

Premium Tolerance: _____

Proposed Insured's Existing Insurance

Insurance Company	Face Amount	Year Issued	Replacement (Yes/No)

1. Date of diagnosis: _____

2. Was the sleep apnea diagnosed as:

- Obstructive Central Mixed Unknown

3. How is the sleep apnea being treated?

- Observation alone Weight Loss
 CPAP mask. If CPAP was given, date use was terminated, if applicable
 Surgery: Date of surgery: _____
 Other: Please give details: _____

4. If surgery was done, was sleep apnea corrected? No Yes; please provide details

5. Has the client had any of the following?

- Arrhythmia Chest pain or CAD? Depression
 Lung Disease Overweight

6. Please list current medications (including inhalers):

Name of Medication	Dosage	Reason

7. Are there any other health issues? (Additional Questionnaires may be required) No Yes

If yes, please provide details: _____