



### MEDICAL HISTORY QUESTIONNAIRE: SLEEP APNEA

Client Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Gender:  Male  Female Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Tobacco Usage:  Never  Former  Current  
 Date Stopped: \_\_\_\_\_ Type: \_\_\_\_\_

Coverage Information: Type:  Term  WL  UL  VUL  IUL  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: \_\_\_\_\_