# Sleep Apnea

## Questionnaire

Knowledge. Experience. Results.

***Please answer all questions applicable to the client's medical history.***

Producer Name_____ Phone _____ Date_____

Client Name_____ Date of Birth_____ ☐Male ☐Female

Face Amount _____ Max Premium $_____ /yr. ☐Term ☐Permanent

Has the client ever used any form of tobacco (cigarettes, cigars, pipe, snuff, etc.)? ☐Yes ☐No

Frequency_____ Date of last use _____ Type _____

Date of diagnosis_____ Diagnosed as ☐Obstructive ☐Central ☐Mixed ☐Unknown

Severity ☐Severe ☐Moderate ☐Mild

Has an overnight sleep study been done ☐Yes ☐No
If yes, provide sleep index AHI_____ RDI_____ Lowest oxygen saturation_____%

How is the sleep apnea being treated
☐No treatment ☐Medicated ☐Weight loss ☐CPAP Mask
☐Surgery (UPPP) ☐Surgery (tracheotomy) ☐Other_____

Does the client have any of the following (if yes, provide details below)
☐Overweight ☐Arrhythmia ☐Coronary Artery Disease ☐Stroke ☐Depression ☐Lung Disease

Does the client use alcohol ☐Yes ☐No (if yes, describe usage below)

| Name of Medication (prescription or otherwise) | Dates Used | Quantity Taken | Frequency Taken |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

List any other major health problems the client has:

**Questions? Call Jim or Teresa at 877.564.1707.**
**Please email the completed form to jrmosel@moseleymcgill.com.**



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