MEDICAL HISTORY QUESTIONNAIRE: SLEEP APNEA

Client Name: _____ Date of Birth: _____

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. What severity as determined by the sleep study? ☐ Mild ☐ Moderate ☐ Severe

4. How is the sleep apnea being treated?

☐ Observation alone ☐ Weight Loss ☐ Oral Appliance ☐ Inspire Implant

☐ CPAP / BiPAP / APAP machine. Are you compliant with nightly use (> 4 hours) ☐ Yes ☐ No

☐ Surgery: Date of surgery and type (i.e.uvulopalatopharyngoplasty (UPPP), tracheostomy, etc.)

☐ Other: Please give details:

_____

_____

5. If treatment was surgery, oral appliance, weight loss or another therapy aside from CPAP or Inspire therapies, has a repeat sleep study been completed to confirm the sleep apnea has been corrected? ☐ Yes ☐ No

6. Has the client had any of the following?

☐ Arrhythmia ☐ Chest pain or CAD? ☐ Depression ☐ Lung Disease ☐ Hypertension

☐ Require supplemental Oxygen

7. Please list current medications (including inhalers):

Name of Medication	Dosage	Reason

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

If yes, please provide details: _____

_____

_____

_____