Sleep Apnea Questionnaire

Name: _____ Date of Birth: _____

Height: _____ Weight: _____ Sex: M/F

Tobacco Usage: _____ Face Amount: _____

___Term 10 15 20 30 ___UL

1. Please provide date of diagnosis: _____

2. Has the Sleep Apnea been diagnosed as?
___Obstructive ___ Central ___ Mixed ___ Unknown

3. Has the severity of the Sleep Apnea been?
___ Stable ___ Increasing ___ decreasing ___ fluctuating up and down ___ Unknown

4. Has an overnight sleep study (Polysomnogram) been done? ___ No ___ Yes
(If yes, please provide date):_____

What was the Sleep Apnea Index: _____ What was the oxygen saturation? _____%

5. How is the Sleep Apnea being treated?
___ No treatment ___ Medicated ___ Weight Loss
___ CPAP Mask ___ Surgery (UPPP) ___ Surgery (tracheotomy)
___ Other:_____

6. Does the proposed insured have any of the following? (Check all that apply)
___ Overweight ___ Arrhythmia ___ Coronary Artery Disease
___ Stroke ___ Depression ___ Lung Disease
___Other: _____

7. Is the proposed insured taking medications for this condition or any other? ___Yes ___No
(If yes, please provide name, dosage, and frequency): _____
_____
_____
_____

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