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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. 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: _____

_____

_____

_____