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: ______________

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4. If surgery was done, was sleep apnea corrected? ☐No ☐Yes; Please provide details ______________________________

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5. Has the client had any of the following?

☐Arrhythmia ☐Chest pain or CAD? ☐Depression

☐Lung Disease ☐Overweight ☐Abnormal

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: ______________________________

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