



Sleep Apnea Questionnaire

Agent: _____ Phone: _____ Fax: _____
Client: _____ DOB : _____ Male Female
Product/Face Amount: _____ Height: _____ Weight: _____

* **TOBACCO/NICOTINE USE (past or present):** YES*** NO

***Please provide details as to any past or present use of tobacco or nicotine products, including type of use, duration & frequency of use, date quit, etc.:

* **Date of diagnosis:**

* **What specific symptoms lead to you seeking consultation and diagnosis?**

* **Was an overnight sleep study performed to confirm a diagnosis of sleep apnea?**

YES*** NO (If "NO", what was the diagnosis based upon?):

***If "YES", were you provided with any *specific* results (please list any specific results provided to you, or attach copy of overnight sleep study report, if available)

Apnea Index (A.I.):

Respiratory Distress Index (R.D.I.):

Apnea/Hypopnea Index (A.H.I.):

Oxygen saturation (highest, average and/or lowest oxygen saturation level):

Unknown

***If none of the above specific details were provided, how did the evaluating physician characterize your sleep apnea in general?

MILD

MODERATE

SEVERE

* **What type of Sleep Apnea was diagnosed?**

Obstructive

Central

Mixed

* **Are you presently treated for sleep apnea? If so, please describe treatment: (C-PAP, Oral Appliance, etc.)**

* **Please note date and any results of follow-up sleep studies performed to assess effectiveness of treatment:**

* **Do you presently consume any alcoholic beverages?** (*Please briefly outline alcohol consumption*)

* **MEDICATIONS** - *List ALL current medications, prescription and non-prescription (including vitamins, nutritional supplements, herbal preparations, etc) in the space provided below:*

MEDICATION	DOSE	MEDICATION	DOSE
1.		5.	
2.		6.	
3.		7.	
4.		8.	

* **FAMILY HISTORY:** (*Family history may be a factor in determining rate class*) **Is there a family history (parent or siblings) of the following conditions/disease onset prior to age 60:**

Cardiac Disease YES NO *Diabetes* YES NO
Stroke or TIA YES NO *Cancer* YES NO

Please provide details for any "YES" response below (attach additional sheet if necessary)

FAMILIAL RELATIONSHIP	SPECIFIC CONDITION(S)	AGE WHEN DIAGNOSED	CURRENT AGE (if living)	DECEASED (list age @ time of death)
<i>FATHER</i>				
<i>MOTHER</i>				
<i>SIBLING 1</i>				
<i>SIBLING 2</i>				

* **Do you have any other significant health issues or medical conditions not outlined or mentioned on this form?** (*Complete additional questionnaires, as indicated*)

Condition(s) - List treatment and current status:

NONE - NO other medical conditions or health issues.

* **Have you been previously declined, postponed or rated for life coverage? If so, please outline the circumstances in detail. Include date, insurance company name, reason for decision, as provided by the carrier and the nature of any prior application/submission (formal application vs. informal/trial submission), etc.**

* **Are there any other health factors, circumstances or information you consider to be important in evaluating you as an applicant for life insurance?**