Sleep Apnea Questionnaire

Name _____ Sex M F Date of Birth _____

Height _____ Weight _____ Smoker? Y N State _____

Coverage Desired? _____ Amount _____ Plan Desired? _____

Have you ever been Rated or Declined for insurance? If YES Complete details please
_____

Have you ever been told that you had Sleep Apnea? Y N
If YES, Complete details and dates please _____

Was sleep study done? Y N If yes, Date _____

How is sleep apnea being treated?

CPAP Mask Y N If Yes, Dates (from – to) _____
Weight Loss Y N If Yes, How much did you used to weigh? _____
Surgery Y N If Yes, Dates and Procedures _____
Other Y N Details please _____

Have you had a Treadmill EKG or any type of Stress Test? If so, When? _____
Were the results normal? _____

What have been your recent Blood Pressure readings? _____
What has been your recent Cholesterol readings? _____

Have you been diagnosed with any of the following? (circle those that apply)
High Blood Pressure Lung Disease Coronary Artery Disease Heart Disease
Depression Overweight Arrhythmia Stroke Heart Attack

Do you have any Family History of Heart Disease or Diabetes? _____
_____

Please list all medications being taken: _____
_____

Do you have any other major health problems? (example: cancer, etc)?
_____

Broker Submitting Questionnaire: _____
Address _____
Phone: _____ FAX: _____ E-mail: _____

Please send completed form: Victorson Associates, Inc. PO Box 863 Smithtown, NY 11787
You may Fax to: (631) 265-7054 or E-mail to: vainc@victorson.com