



Insurance Designers of Central Texas, LLC

## Sleep Apnea Questionnaire

12466 Los Indios Trail #100 Austin, TX 78729  
Phone 512-257-9700 FAX 512-257-9701

Today's Date:

Agent:

Full Name:

Male or Female?

Height and weight:

Date of Birth:

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**NOTE: If you are able to fax us a copy of your sleep study reports, that will help us get the most accurate tentative offer.**

1. Month and year diagnosed: \_\_\_\_\_ Age at diagnosis: \_\_\_\_\_

2. Was the sleep apnea diagnosed as:

Obstructive

Central

And is it diagnosed as  Mild  Moderate  Severe

**(Please call your doctor and ask for the specific diagnosis if you are not sure).**

3. When was your most recent sleep study (month and year)? \_\_\_\_\_

4. How is the sleep apnea being treated (check all that apply)?

Observation alone

Recommended weight loss

CPAP machine

BiPAP mask

Surgery

Other:

5. Are you compliant with your treatment?  Yes  No

6. What medications do you take, reason, dosage and how often?

7. Do you ever get drowsy during the day or while driving?  Yes  No

If yes, list details:

8. How often do you see your doctor?

Every six months       Every 12 months       Other (explain):

9. Has your weight remained stable in the past year?  Yes  No

If no: Lost \_\_\_\_\_ pounds OR Gained \_\_\_\_\_ pounds

10. Please indicate type of tobacco EVER used:

Type:	Amount per (circle frequency):	Date last used:	Still use?
<input type="checkbox"/> Smokeless	<input type="checkbox"/> daily/monthly/yearly	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Cigarettes	<input type="checkbox"/> per day/month/year	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Cigar	<input type="checkbox"/> per day/month/year	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Patch/Gum	<input type="checkbox"/> per day/month/year	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No