SLEEP APNEA

Client's Name ____

If your client has sleep apnea, please answer the following:

1. Please list 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 ☐ surgery
   - ☐ other, please give details ____

4. Is your client on any medications?
   - ☐ yes, please give details ____
   - ☐ no

5. Please check if your client has had any of the following:
   - ☐ lung disease ☐ overweight
   - ☐ chest pain or coronary artery disease
   - ☐ arrhythmia ☐ stroke ☐ depression

6. Has your client smoked cigarettes in the last 12 months?
   - ☐ yes
   - ☐ no

7. Please note date of most recent sleep study and attach a copy of the report. ____________________________________ (date)

8. Does your client have any other major health problems (example: cancer, etc.)?
   - ☐ yes, please give details ____
   - ☐ no

Agents name: Agents Tell # Agent Fax #
Date Submitted: Agents e-mail address:

PLEASE FAX TO BEST MARKETING AT 1-781 643-2775