SLEEP APNEA

CLIENT NAME: _____
Submit the Client Information Questionnaire with this form

1. 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; if CPAP given, date use was terminated _____
   ☐surgery; give date _____
   ☐other; please give details _____

4. If surgery was done, was sleep apnea corrected? (give full details)

5. Has client had any of the following?
   ☐lung disease
   ☐overweight
   ☐chest pain or coronary artery disease
   ☐depression
   ☐stroke
   ☐arrhythmia

6. Is client on any medications? (accurate name, dosage, and reason)

7. Does client have any other health issues? (additional questionnaires may be required)

PRODUCER NAME:_____

Please fax to 612-392-7644 or email to mvp@mvpservicesolutions.com