

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)