SLEEP APNEA CHRONIC DISEASE MANAGEMENT FORM

MINISTRY WELLNESS CENTER

PERSONAL INFORMATION

Full Name :

Date of Birth : D D M M Y Y

E-Mail :

Phone Number :

Gender : ☐ Male ☐ Female

Weight (lbs) :

Height :

SLEEP APNEA HISTORY

Have you ever been told you may have sleep apnea?

☐ Yes — If yes, how long have you been aware of this?

☐ No

If you were told to use a machine, which machine would it be?

If you were told to take medications, please list them.

Is there an immediate family member with a history of sleep apnea? ☐ Yes ☐ No

SYMPTOMS

Have you been told you snore heavily when sleeping? ☐ Yes ☐ No

Do you wake up tired or refreshed? ☐ Yes ☐ No

Do you fall asleep easily during the day? ☐ Yes ☐ No

BODY COMPOSITION

Is your Body Mass Index (BMI) 25% or greater? ☐ Yes ☐ No

THANK YOU FOR YOUR INFORMATION