RESET

SLEEP APNEA

AGENT NAME: _____

CLIENT NAME: _____ **Date:** _____

1. 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; Date of surgery: _____

☐ Other; please give details _____

4. If surgery was done, was sleep apnea corrected? ☐ No ☐ Yes; please give details

_____

_____

5. Has client had any of the following?

☐ lung disease ☐ overweight ☐ chest pain or coronary artery disease
☐ depression ☐ stroke ☐ arrhythmia

6. Is client taking any medication, including inhalers? (accurate name, dosage, and reason)

(Accurate) Name of Medication	Dosage	Reason

7. Are there any other health problems? (additional questionnaires may be required) ☐ No ☐ Yes; please give details

_____

_____

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