

Sleep History By Patient

Patient
MDA #

Print Date

Sleep Center

DOB

FC

SEX

Date: _____ Time: _____

Main Sleep Complaint: _____

Please check any of the following which you are now experiencing or have experienced in the past:

Diabetes	<input type="radio"/> Now	<input type="radio"/> Past	<input type="radio"/> N/A	Anemia	<input type="radio"/> Now	<input type="radio"/> Past	<input type="radio"/> N/A
High Blood Pressure	<input type="radio"/> Now	<input type="radio"/> Past	<input type="radio"/> N/A	Peptic Ulcers	<input type="radio"/> Now	<input type="radio"/> Past	<input type="radio"/> N/A
Stroke	<input type="radio"/> Now	<input type="radio"/> Past	<input type="radio"/> N/A	Acid Reflux (Heartburn)	<input type="radio"/> Now	<input type="radio"/> Past	<input type="radio"/> N/A
Heart Disease or CHF	<input type="radio"/> Now	<input type="radio"/> Past	<input type="radio"/> N/A	Kidney Disease	<input type="radio"/> Now	<input type="radio"/> Past	<input type="radio"/> N/A
Heart Attack	<input type="radio"/> Now	<input type="radio"/> Past	<input type="radio"/> N/A	Thyroid Disease	<input type="radio"/> Now	<input type="radio"/> Past	<input type="radio"/> N/A
Angina	<input type="radio"/> Now	<input type="radio"/> Past	<input type="radio"/> N/A	Arthritis	<input type="radio"/> Now	<input type="radio"/> Past	<input type="radio"/> N/A
Emphysema or COPD	<input type="radio"/> Now	<input type="radio"/> Past	<input type="radio"/> N/A	Back Pain	<input type="radio"/> Now	<input type="radio"/> Past	<input type="radio"/> N/A
Asthma	<input type="radio"/> Now	<input type="radio"/> Past	<input type="radio"/> N/A	Head Trauma	<input type="radio"/> Now	<input type="radio"/> Past	<input type="radio"/> N/A
Tuberculosis	<input type="radio"/> Now	<input type="radio"/> Past	<input type="radio"/> N/A	Severe Headaches	<input type="radio"/> Now	<input type="radio"/> Past	<input type="radio"/> N/A
Other Lung Disease	<input type="radio"/> Now	<input type="radio"/> Past	<input type="radio"/> N/A	Epilepsy (Seizures)	<input type="radio"/> Now	<input type="radio"/> Past	<input type="radio"/> N/A
Nasal Allergies	<input type="radio"/> Now	<input type="radio"/> Past	<input type="radio"/> N/A	Fainting	<input type="radio"/> Now	<input type="radio"/> Past	<input type="radio"/> N/A
Runny or Blocked Nose	<input type="radio"/> Now	<input type="radio"/> Past	<input type="radio"/> N/A	Depression	<input type="radio"/> Now	<input type="radio"/> Past	<input type="radio"/> N/A
Hormonal Problem	<input type="radio"/> Now	<input type="radio"/> Past	<input type="radio"/> N/A	Anxiety Disorder	<input type="radio"/> Now	<input type="radio"/> Past	<input type="radio"/> N/A
Urological Problem	<input type="radio"/> Now	<input type="radio"/> Past	<input type="radio"/> N/A	Problems with Alcohol	<input type="radio"/> Now	<input type="radio"/> Past	<input type="radio"/> N/A
Prostate Disease	<input type="radio"/> Now	<input type="radio"/> Past	<input type="radio"/> N/A	Problems with Drugs	<input type="radio"/> Now	<input type="radio"/> Past	<input type="radio"/> N/A

Do you smoke cigarettes? _____ Cigars, Pipe or other? _____

How many per day?: _____ Number of years: _____ Year quit: _____

Marital Status: _____ Occupation: _____

Previous Jobs: _____

Who referred you to this office? _____

Sleep Schedule:

What time do you go to bed on WEEKDAYS? _____ AM or PM

Do you nap? Yes No

What time do you get up on WEEKDAYS? _____ AM or PM

How often do you nap? _____ times per week

What time do you go to bed on WEEKENDS? _____ AM or PM

How long are the naps? _____ minutes

What time do you get up on WEEKENDS? _____ AM or PM

Do you awaken refreshed? Yes No

Are you a shift worker? Yes No If yes, what kind of shift do you work? _____

Patient Signature: _____ Print Name: _____ Date: _____

