

Height: _____ Neck size: _____
 Weight: _____ Weight 5 years ago: _____

MEDICAL HISTORY

Please check all that apply:

- Did you ever have?
- | | |
|--|---|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Emphysema |
| <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Kidney Disease |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Migraines |
| <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Irregular Rhythm |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Gastric Reflux | <input type="checkbox"/> Congestive Heart Failure |
| <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Rhinitis/Sinusitis |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Claustrophobia/Anxiety |
| <input type="checkbox"/> Others: _____ | |

SURGICAL HISTORY

Please list all surgeries, with dates:

- Tonsils/Adenoids
 Sinus/Nasal Surgery
 Heart Surgery
 Heart Angiogram/Stents
 Others: _____

EPWORTH SLEEPINESS SCALE

- 0 = NEVER doze off**
1 = SLIGHT chance of dozing
2 = MODERATE chance of dozing
3 = HIGH chance of dozing

<i>Would you doze off while:</i>	<i>Scale Rating</i>
Sitting and Reading	_____
Watching TV	_____
Sitting inactive in public place	_____
As a passenger in a car	_____
Lying down to rest in the afternoon	_____
Sitting and talking to someone	_____
Sitting quietly after lunch without alcohol	_____
In a car, while stopped in traffic	_____
TOTAL	_____

SOCIAL HISTORY

- Single Married
 Divorced Widowed

Do you have children? _____ How Old? _____

What kind of work? _____

I have a Commercial Driver's License
 Yes No

SOCIAL EXPOSURES

Did you ever smoke? Yes No
 How many packs/day? _____
 Started at what age? _____
 When did you quit? _____

Do you drink alcohol? Yes No
 How much? _____
 What time of day? _____
 Were you ever an alcoholic? Yes No

Do you consume caffeine? Yes No
 Coffee Pop Energy Drinks
 How much? _____

Did you use illicit substances? Yes No
 Meth Marijuana Others: _____
 How much? _____

FAMILY HISTORY

My Mother is: Alive Deceased
 What age? _____
 Health problems: _____

My Father is: Alive Deceased
 What age? _____
 Health problems: _____

Any family history of:
 Cancer Heart Disease Stroke
 Seizures Sleep Apnea Insomnia
 Others: _____

SLEEP HISTORY

Please complete the following:

What time do you go to bed? _____

On days off: _____

How long before you fall asleep? _____

How many times do you wake up during the night?

How many times do you go to the bathroom during the night? _____

What time do you get out of bed in the morning?

On days off: _____

Use an Alarm Clock? Yes No

What time do you have to get to work?

Do you nap? Yes No
How long? _____

Do you doze off? Yes No
What time of day? _____

Anyone share your bed? Yes No

Do you sleep better on vacation (away from home?)
 Yes No

Please explain _____

Do you exercise? Yes No
What kind? _____

What time of day? _____

ALLERGIES

Any Drug Allergies? Yes No

Please list: _____

SLEEP HISTORY

Please check all that apply:

- Driving accidents or near accidents due to sleepiness
- Significant weight gain
- Snore
- Awaken with choking sensation

- Trouble falling asleep
- Trouble remaining asleep
- Awaken with intense anxiety
- Feel depressed during the day

- Legs jerk and kick during sleep
- Uncomfortable leg sensations that improve with movement
- Uncomfortable leg sensations always worsening in the evenings

- Jaw aches in the morning
- Grind teeth in sleep
- Sleep Talking as an adult
- Sleep Walking as an adult
- Acting out your dreams
- Nighttime seizures
- Shift Work

- Awaken with back pain
- Awaken with headaches
- Awaken with heartburn or acid reflux
- Awaken with cough or shortness of breath

- Vivid dreams or hallucinations while awake
- Paralysis or inability to move upon awakening
- Sudden feeling of weakness in legs or knees

MEDICATIONS

Current Medication	Dose	Reason

Use back if more space needed