



Name: \_\_\_\_\_ Age: \_\_\_\_\_ Birthdate: \_\_\_\_\_

How did you hear about us? \_\_\_\_\_

Name and address of your primary care provider (your regular family doctor):  
\_\_\_\_\_

\_\_\_\_\_ Phone: \_\_\_\_\_

Reason for today's visit?  
\_\_\_\_\_

Have you ever had a sleep study? \_\_\_ No \_\_\_ Yes: Date: \_\_\_\_\_ Where: \_\_\_\_\_

Results: \_\_\_\_\_

**PAST HISTORY**

Please list any prior major illnesses and/or injuries:  
\_\_\_\_\_  
\_\_\_\_\_

Please list any surgeries or hospitalizations:	Year	Complications

Please list current medication(s) including aspirin:

Drug	Dose	Frequency	Drug	Dose	Frequency

**Please list any allergies or reactions to medications or other materials:**

Do you smoke, or have you smoked previously?  
\_\_\_ Yes, I quit smoking \_\_\_\_\_ (years/months) ago.  
\_\_\_ Yes, I've smoked \_\_\_ packs of cigarettes per day for \_\_\_ years.  
\_\_\_ Yes, I smoke cigars or a pipe.  
\_\_\_ No, I have never smoked.

Do you drink alcohol? \_\_\_ Yes: \_\_\_ Daily \_\_\_ One or more times a week \_\_\_ Occasionally  
\_\_\_ No

What is your occupation? (or if retired, prior occupation) \_\_\_\_\_