

MEDICAL HISTORY FORM

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 MEDICATIONS INCLUDING ASPIRIN:

| DRUG | DOSE | FREQUENCY | DRUG | DOSE | FREQUENCY |
|------|------|-----------|------|------|-----------|
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| | | | | | |
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PLEASE LIST ANY ALLERGIES OR REACTIONS TO MEDICATIONS AND/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) _____