Name_____
DOB_____
Why were you referred to this clinic?

_____
Primary Care Physician_____
Referring Physician_____

Medical History (please check all that apply)

□Diabetes □Asthma □Stroke
□Thyroid disease□Arthritis □Migraines
□Heart disease □Anemia □ALS/MS
□COPD □Emphysema □Seizures
□Depression or Anxiety □Irreg heart rhythm
□Cancer: Type_____
□Other_____

Surgical History (please list all surgeries/dates)

□Tonsils/adenoids □Sinus/nasal surgery
□Heart surgery/stent placement
□Other_____
_____
_____

Social History

□Single □Married □Widowed □Divorced
Current employment_____
Retired? Yes No Stay @ home? Yes No
Shift work: Yes No
CDL: Yes No

Allergies

Medication allergies:_____
_____
□cats □dogs □mold □grass □dust □pollen
□other_____

Please list all medications and dosages

(Include supplements and over-the-counter meds)
1._____
2._____
3._____
4._____
5._____
6._____
7._____
8._____
9._____
10._____
11._____

SIOUX FALLS Sleep Center

Social Exposures

Did you ever smoke? Yes No
How many packs per day?_____
When did you quit?_____

Do you drink alcohol? Yes No
How many drinks per day?_____
Have you ever been an alcoholic? Yes No

Do you consume caffeine? Yes No
How many ounces per day?_____
□coffee □pop □energy drinks
Do/did you use illicit substances? Yes No
□meth □pot □other_____

Other exposures
□Asbestos □Radon □Farm dust
□Tuberculosis □Second hand smoke

Family History

My mother is □alive □deceased Age_____
Health problems:_____
_____
My father is □alive □deceased Age_____
Health problems:_____
_____
Do your children have any health problems?
_____
Any family history of:
□Heart disease □Stroke □Seizures
□Sleep Apnea □Insomnia □Asthma
□Emphysema □Allergies
□Cancer/Type:_____

Past Sleep Evaluation and Treatment

□ I have had a previous overnight sleep study
The results of my previous sleep study were:
_____
_____