dsm sleep Specialists PLC

1275 NW 128th St Ste 200
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# Sleep Medicine Patient History Form

Name: _____ DOB: _____

Allergies to Medications: ☐ Yes ☐ No

If yes, please identify medication name and reaction:

_____

_____

## List Medications and Dosage

| (Please include inhalers, nebulized treatments, patches, herbal supplements, over the counter meds & vitamins) | Dose/mg | How many tabs | How many times per day |
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**Medical History**: Please check all medical conditions you have been treated for

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| ☐ Hypothyroidism | ☐ High Cholesterol |
| ☐ Atrial Fibrillation | ☐ Excessive Daytime Sleepiness |
| ☐ Anxiety | ☐ High Blood Pressure |
| ☐ Asthma | ☐ Insomnia |
| ☐ Back pain | ☐ Iron Deficiency Anemia |
| ☐ Heart Disease (Coronary Artery Disease) | ☐ Narcolepsy |
| ☐ Cancer: Type_____ Year _____ | ☐ Osteoarthritis |
| ☐ COPD (Chronic Obstructive Pulmonary Disease) | ☐ OSA (Obstructive Sleep Apnea) |
| ☐ Stroke (CVA-Cerebral Vascular Accident Stroke) | ☐ Parasomnia |
| ☐ DVT (Deep Vein Thrombosis) | ☐ Restless Legs Syndrome |
| ☐ Depression | ☐ Rheumatoid Arthritis |
| ☐ Diabetes<br>Type 1 ☐ Controlled ☐ Uncontrolled ☐<br>Type 2 ☐ Controlled ☐ Uncontrolled ☐ | ☐ Seasonal Allergies |
| ☐ Fibromyalgia | ☐ Seizure Disorders |

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| | |
|---|---|
| ☐ GERD (Gastroesophageal Reflux Disease) | ☐ Shift Work Sleep Disorder |
| ☐ Head Injury | Please list any other conditions you have been treated for that are not included above: |
| ☐ PE (Pulmonary Embolism) | _____ |

**Family History:** Please check if anyone in your family (not including yourself) have or have had any of the following

☐ Unknown Family History ☐ Adopted

| | |
|---|---|
| Sleep Apnea ☐ Mother ☐ Father ☐ Brother ☐ Sister | Heart Disease ☐ Mother ☐ Father ☐ Brother ☐ Sister |
| Narcolepsy ☐ Mother ☐ Father ☐ Brother ☐ Sister | High Blood Pressure ☐ Mother ☐ Father ☐ Brother ☐ Sister |
| Insomnia ☐ Mother ☐ Father ☐ Brother ☐ Sister | Restless Legs Syndrome ☐ Mother ☐ Father ☐ Brother ☐ Sister |
| Sleep Walking ☐ Mother ☐ Father ☐ Brother ☐ Sister | Circadian Rhythm Disorder ☐ Mother ☐ Father ☐ Brother ☐ Sister |
| Sleep Talking ☐ Mother ☐ Father ☐ Brother ☐ Sister | Any other diseases or disorders that are common in your family |
| Stroke ☐ Mother ☐ Father ☐ Brother ☐ Sister | _____ |

**Social History:** Please check all that apply and complete blanks as appropriate

| | | |
|---|---|---|
| Tobacco<br>☐ Never<br>☐ Cigarettes ☐ Pipes ☐ Cigars<br>☐ Former:<br># of packs/bowls per day _____<br># of years _____<br>Year quit _____<br>☐ Current:<br># of packs/bowls per day: _____<br># of years _____ | Alcohol<br>☐ Never<br>☐ Occasional: Amount _____<br>☐ Light: less than 2 per day<br>☐ Moderate: 2-3 per day<br>☐ Heavy: 4 or more per day<br>Type:<br>☐ Beer ☐ Wine ☐ Hard Liquor | Caffeine-Daily Intake<br>☐ None<br>☐ Coffee: # of 8oz cups_____<br>☐ Tea: # of 8oz cups_____<br>☐ Soda: # of 12oz bottles/cans ____<br>☐ Energy Drinks: How much _____<br>What time do you stop drinking caffeine?<br>_____ |
| Living Situation<br>☐ Married, living with spouse<br>☐ Single, live alone<br>☐ Single, living with significant other<br>☐ Single, living with family member<br>☐ Divorced<br>☐ Widowed<br>☐ Nursing home/Group home/Asst living | Employment Status<br>☐ Full-time<br>Occupation_____<br>☐ Part-time<br>Occupation_____<br>Hours you work/shift<br>_____<br>☐ Unemployed<br>☐ looking for work ☐ not looking<br>☐ Disables<br>Reason_____<br>☐ Retired | |

**Past Surgeries**: Please check all that apply and enter year of surgery as applicable

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|---|---|
| ☐ Adenoids removed _____ | ☐Cesarean Delivery _____ |
| ☐ Appendix _____ | ☐ Gall Bladder Removal _____ |
| ☐ Back Surgery _____ | ☐ Coronary Artery bypass Graft _____ |
| ☐ Bariatric Surgery<br>Type: _____ _____ | ☐ Foot Surgery<br>Type: _____<br>_____ |
| ☐ Bunionectomy _____ | ☐ Hysterectomy _____ |

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| | |
|---|---|
| Cardiac<br>☐ Ablation _____<br>☐ Catheterization _____<br># Stents if applicable _____ _____<br>☐ Pacemaker/Defibrillator implant _____<br>☐ Cardioversion Electric _____ | ☐ Hernia Repair _____<br>☐ Umbilical ☐ Inguinal<br>☐ Right ☐ Left<br>☐ Joint Replacement<br>☐ Right ☐ Left Joint _____<br>☐ Sinus Surgery _____ |
| Carpal Tunnel Release<br>☐ Right ☐ Left ☐ Both _____ | ☐ Thyroid Surgery _____<br>☐ Tonsils Removed _____ |
| Rotator Cuff<br>☐ Right ☐ Left _____ | ☐ Tubal Ligation _____<br>☐ Vasectomy _____ |

Please list any other surgeries or hospitalizations not included above and year: _____

_____

_____

_____

_____