dsm sleep Specialists PLC

1275 NW 128th St, Ste 200
Clive, IA 50325
Phone: (515) 224-3948
Fax: (515) 224-0469

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

Medical History: Please check all medical conditions you have been treated for

☐ 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

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☐ Diabetes Type 1 ☐ Controlled ☐ Uncontrolled ☐ Type 2 ☐ Controlled ☐ Uncontrolled ☐	☐ Seasonal Allergies
☐ Fibromyalgia	☐ Seizure Disorders
☐ 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 ☐ Never ☐ Cigarettes ☐ Pipes ☐ Cigars ☐ Former: # of packs _____ # of years _____ Year quit _____ ☐ Current: # of packs _____ # of years _____	Alcohol ☐ Never ☐ Occasional: Amount _____ ☐ Light: less than 2 per day ☐ Moderate: 2-3 per day ☐ Heavy: 4 or more per day Type: ☐ Beer ☐ Wine ☐ Hard Liquor	Caffeine-Daily Intake ☐ None ☐ Coffee: # of 8oz cups_____ ☐ Tea: # of 8oz cups_____ ☐ Soda: # of 12oz bottles/cans _____ ☐ Energy Drinks: How much _____ What time do you stop drinking caffeine? _____

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Living Situation ☐ Married, living with spouse ☐ Single, live alone ☐ Single, living with significant other ☐ Single, living with family ☐ Divorced ☐ Widowed ☐ Nursing home/Group home/Asst living	Employment Status ☐ Full-time ☐ Part-time Occupation_____ Hours you work/shift _____ ☐ Unemployed ☐ looking for work ☐ not looking ☐ Disabled Reason_____ ☐ Retired	

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

☐ Adenoids removed	☐Cesarean Delivery
☐ Appendix	☐ Gall Bladder Removal
☐ Back Surgery	☐ Coronary Artery bypass Graft
☐ Bariatric Surgery Type: _____	☐ Foot Surgery Type: _____
☐ Bunionectomy	☐ Hysterectomy
Cardiac ☐ Ablation ☐ Catheterization # Stents if applicable _____ ☐ Pacemaker/Defibrillator implant ☐ Cardioversion Electric	☐ Hernia Repair ☐ Umbilical ☐ Inguinal ☐ Right ☐ Left ☐ Joint Replacement ☐ Right ☐ Left Joint ☐ Sinus Surgery
Carpal Tunnel Release ☐ Right ☐ Left ☐ Both	☐ Thyroid Surgery ☐ Tonsils Removed
Rotator Cuff ☐ Right ☐ Left	☐ Tubal Ligation ☐ Vasectomy

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

_____

_____

_____

_____

_____