CIC Sleep Medicine Patient History Form

Name:_____ **Date of Birth:**_____

Allergies to medications: YES NO

If yes, please identify Drug name and reaction:

Medications (**please include over the counter meds and vitamins**):

Medication name: If you brought a list with you today, write **see list**	Dose	How many tabs	How many times a DAY	

Medical History: Please **circle** those medical problems that you have been treated for:

Hypothyroidism

Atrial Fibrillation

Anxiety

Asthma

Back Pain

Heart Disease (coronary artery disease)

Cancer: type year

_____.

COPD

Stroke-CVA

DVT (deep vein thrombosis)

Depression

Diabetes type 1 type2

If diabetic is it: controlled or uncontrolled

Fibromyalgia

GERD-heartburn

Head Injury

PE (pulmonary embolism)

High Cholesterol

Excessive Day Time Sleepiness

High Blood Pressure

Insomnia

Iron Deficiency Anemia

Narcolepsy

Osteoarthritis

Obesity

Sleep Apnea

Parasomnia: example- sleep walking/talking

Restless Legs Syndrome

Rheumatoid Arthritis

Seasonal Allergies

Seizure Disorder

Shift Work Disorder

Please list any other conditions you have been treated for that are not included above:___

_____.

Family History: Does anyone in your family- (not including yourself) have or has had:

Please indicate which family member. **MOTHER=M, FATHER=F, SISTER=S, BROTHER=B**

Sleep Apnea	M	F	S	B
Narcolepsy	M	F	S	B
Insomnia	M	F	S	B
Sleep Walking	M	F	S	B
Sleep Talking	M	F	S	B
Stroke	M	F	S	B
Heart Disease	M	F	S	B
High Blood pressure	M	F	S	B
Diabetes Mellitus	M	F	S	B
Restless Leg Syndrome	M	F	S	B
Circadian Rhythm Disorder	M	F	S	B

Any other diseases or disorders that are common in your family:

_____

Unknown Family History OR Adopted

Social history: Please **circle** all that apply and fill in blanks as appropriate.

Tobacco: NEVER

Cigarettes /Pipes /Cigars

FORMER: how many packs/bowls per day_____. how many years did you smoke_____. when did you quit_____.

CURRENT: how many packs/bowls per day_____. how many years have you been smoking_____.

Chew: how much per day .

Alcohol: NEVER

OCCASIONAL:_____how much/how often

LIGHT: less than 2 per day

MODERATE: 2-3 drinks per day

HEAVY: 4 more drinks per day

TYPE: Beer Wine hard liquor

Living Situation:

Married, living with spouse

Single lives alone

Single living with significant other

Single living with family member

Divorced

Widowed

Employment Status:

Hours you work-Shift:_____.

Full-time Employment: Occupation_____.

Part-time Employment: Occupation_____.

Unemployment

Disabled—due to:_____.

Retired from:_____.

Caffeine-daily intake: NONE

Coffee - how many 8oz cups_____

Tea_____how many 8oz glasses

Soda_____how many 12oz cans

Energy Drinks_____.

What time do you stop drinking caffeine?_____

Past Surgeries: Please **circle** all that apply and **fill in year** of surgery.

Adenoids Removed: yr_____.

Appendix Removal: yr_____.

Back Surgery: yr_____.

Bariatric Surgery: type_____yr_____.

Cardiac Ablation: yr_____.

Cardiac Catheterization:
How many stents if any_____.yr_____.

Pacemaker—Defibrillator Placement: yr:_____.

Cardioversion: (shocked your heart to regain normal rhythm)
how many_____yr_____.

Carpal tunnel: Left - Right yr_____. Cataract

Surgery: Left - Rightyr_____.

Cesarean Delivery: yr_____.

Gall Bladder Removal: yr_____.

Coronary Artery Bypass Graft:
how many bypasses_____.yr_____.

Foot Surgery: type_____.yr_____.

Hernia repair: umbical—inguinal—right—left. yr._____

Hysterectomy: yr_____.

Joint Replacement: Left Right. yr_____.

which joint:_____

_____.

Deviated Septum Surgery: yr_____.

Sinus Surgery: yr_____.

Thyroid Surgery: yr. _____.

Tonsils Removed: yr_____.

Tubal ligation: yr_____.

Vasectomy: yr_____.

Please List any other Surgeries not included above and year:_____

_____

Other Hospitlizations:_____