HEALTH HISTORY

FIRST NAME	LAST NAME	DOB

HAVE YOU EVER HAD AN OVERNIGHT SLEEP TEST? ☐ YES ☐ NO	**NAME & LOCATION**
IF YES, WHO WAS ORDERING PHYSICIAN?	**DATE OF TEST**
ARE YOU ALLERGIC TO LATEX? ☐ YES ☐ NO	**DO YOU TAKE MEDICATIONS FOR THE FOLLOWING?** BLOOD PRESSURE ANXIEY ANTI-DEPRESSANTS SLEEPING PILLS
LIST ANY OTHER ALLERGIES:	**LIST ANY OTHER MEDICATIONS:**
DO YOU WEAR DENTURES? ☐ YES ☐ NO	

FAMILY HISTORY

HAVE ANY BLOOD RELATIVES BEEN DIAGNOSED OR TREATED FOR ANY OF THE FOLLOWING?

☐ HEART DISEASE ☐ HIGH BLOOD PRESSURE ☐ DIABETES ☐ MOOD DISORDER ☐ SLEEP

SOCIAL HISTORY

ALCOHOL CONSUMPTION: HOW OFTEN DO YOU CONSUME ALCOHOL WITHIN 2-3 HOURS OF BEDTIME?

☐ NEVER ☐ OCCASIONALLY ☐ 1-2X/WK ☐ 2-3X/WK ☐ DAILY

SEDATIVE CONSUMPTION: HOW OFTEN DO YOU TAKE SEDATIVES WITHIN 2-3 HOURS OF BEDTIME?

☐ NEVER ☐ OCCASIONALLY ☐ 1-2X/WK ☐ 2-3X/WK ☐ DAILY

CAFFEINE CONSUMPTION: HOW OFTEN DO YOU CONSUME CAFFEINE WITHIN 2-3 HOURS OF BEDTIME?

☐ NEVER ☐ OCCASIONALLY ☐ 1-2X/WK ☐ 2-3X/WK ☐ DAILY

MEDICAL HISTORY

MARK ONE IN EACH ROW	YES	NO		YES	NO		YES	NO
DIABETES I II			HEART DISEASE			BLOOD TRANSFUSION		
HIGH BLOOD PRESSURE			ANGINA ARTERIOSCLEROSIS			HEMOPHILIA		
LOW BLOOD PRESSURE			CONGESTIVE HEART			AIDS OR HIV ARTHRITIS		
MOOD DISORDER			FAILURE DAMAGED HEART			AUTOIMMUNE DISEASE		
LIVER DISEASE			VALVES HEART ATTACK			RHEUMATOID		
EPILEPSY			HEART MURMUR			ARTHRITIS LUPUS		
NEUROLOGICAL			THYROID PROBLEMS			ASTHMA		
DISORDERS INSOMNIA			ACID REFLUX / HEARTBURN			BRONCHITIS		
FATIGUE			CONGENITAL HEART DEFECT			EMPHYSEMA		
BRAIN FOG			MITRAL VALVE PROLAPSE			SINUS TROUBLE		
MENTAL HEALTH DISORDER			PACEMAKER			TUBERCULOSIS CANCER		
MEMORY LOSS			RHEUMATIC FEVER			CHRONIC PAIN		
HEADACHES/MIGRAINES			STROKE			EXCESSIVE URINATION		
DIFFICULTY CONCENTRATING			ABNORMAL BLEEDING			KIDNEY DISEASE		
UNEXPLAINED WEIGHT LOSS			ANEMIA					
UNEXPLAINED WEIGHT GAIN								
OTHER: ________________			OTHER: ________________			OTHER: ________________		

PATIENT SIGNATURE	DATE

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