PAST SURGICAL HISTORY (CHECK ALL THAT APPLY)

☐ Weight loss surgery ☐ Tonsillectomy

☐ Sinus Surgery ☐ Septoplasty

ADDITIONAL SURGERIES

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

FAMILY HISTORY (CHECK ALL THAT APPLY)

Members	Living or Deceased	Sleep Apnea	Insomnia	Restless Legs	Narcolepsy	Sleep Walking	High Blood Pressure	Stroke	Heart Disease	Diabetes
Father										
Mother										
Brother(s)										
Sister(s)										
Son(s)										
Daughter(s)										

Other significant family history: _____

SOCIAL HISTORY

Do you use tobacco products now? ☐ **Yes** ☐ **No** **In the past?** ☐ **Yes** ☐ **No**

☐ Cigarettes ☐ Electronic Nicotine ☐ Smokeless (dip/chew/snuff)

How much? _____ How long? _____ When did you quit? _____

☐ **I drink alcohol** ☐ Beer ☐ Wine ☐ Liquor ☐ Every Night ☐ _____ Nights per week

How much? _____

Do you have a history of drug use? ☐ **Yes** ☐ **No**

What? _____

☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

☐ Employed ☐ Unemployed ☐ Retired ☐ Part Time

What is / was your occupation? _____

☐ My job requires me to drive

☐ Shift work ☐ permanent night shift ☐ rotating shift Which shift _____

☐ I am current a student

EDUCATION: High School - College - Postgraduate - Other: _____

MEDICATIONS THAT YOU HAVE PREVIOUSLY TRIED FOR SLEEP (CHECK ALL THAT APPLY)

- ☐ Ambien/zolpidem
- ☐ Benadryl
- ☐ Desyrel/trazodone
- ☐ Elavil/amitriptyline
- ☐ Lunesta/eszopidone
- ☐ Melatonin
- ☐ Remeron/mirtazepine
- ☐ Restoril/temazepam
- ☐ Rozerem/Ramelteon
- ☐ Seroquel/quetiapine
- ☐ Silenor/Doxepin
- ☐ Sonata/zaleplon
- ☐ Surorevant/Belsomra
- ☐ Tylenol Pm

PLEASE LIST CURRENT MEDICATIONS AND SUPPLEMENTS OR PROVIDE LIST:

Pharmacy: _____

NAME of Medication	DOSE	FREQUENCY

PAST MEDICAL HISTORY (CHECK ALL THAT APPLY)

- ☐ Acid Reflux / Heartburn
- ☐ ADD/ADHD
- ☐ (Alcohol) (Drug) (Medication) Addiction
- ☐ Anemia
- ☐ Anxiety Disorder
- ☐ Arrhythmia (Atrial Fibrillation)
- ☐ Arthritis
- ☐ Asthma (childhood) (Current)
- ☐ Bipolar Disorder
- ☐ Cancer (Type:_____)
- ☐ COPD / Emphysema
- ☐ COVID-19 Infection
- ☐ Colon Disease / Hemorrhoids
- ☐ Depression
- ☐ Diabetes
- ☐ Epilepsy / Seizures
- ☐ Fibromyalgia
- ☐ Head Injury / TBI
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Menopause
- ☐ Migraine
- ☐ Nasal Allergies (seasonal) (all year)
- ☐ Neuropathy
- ☐ Pain [chronic]
- ☐ Post Traumatic Stress Disorder
- ☐ Pregnancy
- ☐ Prostate Disease
- ☐ Sleep Apnea
- ☐ Stroke
- ☐ Thyroid Disease
- ☐ TIA
- ☐ Additional

_____

_____

_____

_____

What Drugs are you allergic to:

_____ _____

_____ _____