Last Name	First Name	Age	Referring Provider	Primary Care Provider

Social History

Single Married Partner Separated Divorced Widowed _____ (year)

Children/Grandchildren _____ (ages) / Number of Household Members _____

Employment status _____ Occupation: _____

Do you smoke/Vape now? Y N How many packs per day? _____

Did you ever smoke/Vape? Y N What year did you quit? _____

Do you drink alcohol? Y N Type of Alcohol _____ How many drinks per day/week? _____

Past Medical History (Please check all items that you have had in the past or are currently being treated for)

____ High Blood Pressure	____ Diabetes	____ Esophageal Reflux	____ Insomnia
____ High Cholesterol	____ Thyroid Disease	____ Nasal Allergies	____ Sleep Apnea
____ Heart Artery Disease	____ Kidney Disease	____ COPD	____ Narcolepsy
____ A Fib	____ Liver Disease	____ Asthma	____ Restless Legs
____ CHF	____ Chronic Pain	____ Anxiety	____ Parkinson's
____ Vascular Disease	____ Autoimmune Disease	____ Depression	____ Anemia-B12/Iron
____ Varicose Veins	____ Seizures	____ ADD / ADHD	____ Neuropathy
		____ Psychiatric Disorder	Other _____

PRIOR: Heart Attack Stroke / TIA Pancreatitis Head Trauma Mono/Meningitis Cancer_____

Surgical History

Year	Year	Year
_____ Nasal Septal Repair	_____ Sinus Surgery	_____ Palate Surgery
_____ Heart Bypass # _____	_____ Heart/Arterial stents #_____	_____ Carotid Surgery
_____ Cholecystectomy (Gallbladder)	_____ Thyroidectomy	_____ Tonsillectomy / Adenoids
_____ Prostate Surgery	_____ Hysterectomy / Ovaries	_____ Other _____

Family History (check boxes indicating medical problem with family member)

	Mother	Father	Sister	Brother	Daughter	Son
Diabetes	☐	☐	☐	☐	☐	☐
High BP	☐	☐	☐	☐	☐	☐
High Cholesterol	☐	☐	☐	☐	☐	☐
CHF	☐	☐	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐	☐	☐
Stroke/TIA	☐	☐	☐	☐	☐	☐
Kidney Disease	☐	☐	☐	☐	☐	☐
Obesity	☐	☐	☐	☐	☐	☐
Sleep Apnea	☐	☐	☐	☐	☐	☐
Insomnia	☐	☐	☐	☐	☐	☐
Narcolepsy	☐	☐	☐	☐	☐	☐
Sleep Disorder	☐	☐	☐	☐	☐	☐