History and Physical Form

Name_________________

Sleep Study Date___________ Date of Birth____________

Have you had any of the symptoms below newly develop during the past week,
OR if you have had any of the symptoms before, have they gotten worse over the past week?

	Yes	No
Eyes:		
1. Loss of vision	___	___
2. Double vision	___	___
Respiratory:		
1. Shortness of breath	___	___
Cardiac:		
1. Chest pain	___	___
2. Irregular heart beat	___	___
Neurologic:		
1. Paralysis	___	___
2. Slurred speech	___	___
3. Seizures	___	___
4. Loss of consciousness	___	___
5. Lightheadedness	___	___

Past Medical History

Major illnesses, surgeries and hospitalizations in adulthood (please describe the medical problem and give the dates of diagnosis)

Medication and food allergies (please list and describe reaction)

Please turn over & continue

Personal history of any of the following:

	NO	YES, but IS NOT	YES, this IS a

		a current serious health problem	current serious health problem (please describe)
1. Lung disease	___	___	___
2. Asthma	___	___	___
3. Heart disease	___	___	___
4. Hypertension	___	___	___
5. Stroke	___	___	___
6. Diabetes	___	___	___
7. Kidney disease	___	___	___
8. Gastrointestinal condition	___	___	___

Medications Dose Frequency

Contact Information

Phone number ________________ Best time to call _____________

Physician Comments:

________________________________ _____________
Physician Reviewer Date