

PATIENT'S NAME \_\_\_\_\_ Birth Date: \_\_\_\_\_

What medical problem(s) brings you to this office? \_\_\_\_\_

How did you learn about our practice? \_\_\_\_\_

Who are your doctors? \_\_\_\_\_

Do you have any *active* medical problems being treated by a Doctor? \_\_\_\_\_

Do you have any *other* medical problems? \_\_\_\_\_

What PRESCRIPTION medicines do you take and why?

MEDICATION	BEING TAKEN FOR	MEDICATION	BEING TAKEN FOR

What other non – prescription (over the counter, herbal or homeopathic) medications do you take? \_\_\_\_\_

Pharmacy name: \_\_\_\_\_ Phone# \_\_\_\_\_

Please list any hospitalizations or surgeries (Please give date and reason).

HOSPITALIZATION	REASON AND DATE

Do you have any allergies to medications? Please list the names and types of reaction.

ALLERGIC TO	REACTION	ALLERGIC TO	REACTION

Do you have any environmental allergies? ( ) Yes ( ) No. To what? \_\_\_\_\_

\_\_\_\_\_ Have you ever been evaluated with allergy tests? ( ) Yes ( ) No

**SOCIAL HISTORY:**

Occupation: \_\_\_\_\_

Do you smoke? ( ) NO ( ) YES How much? \_\_\_\_\_ packs per day.

Do you drink: Caffeinated beverages? ( ) NO ( ) YES Alcohol? ( ) NO ( ) YES How much? \_\_\_\_\_

Do you live: ( ) Alone? ( ) With Spouse? ( ) with children? ( ) With friends? ( ) Assisted facility

**CONTINUE ON OTHER SIDE**

**FOR CHILDREN:**

Was the mother's pregnancy normal? ( ) Y ( ) N Birth Weight?

Did the child reach his / her milestones ( seating, walking, talking, etc.,) on time? \_\_\_\_\_

**FAMILY HISTORY: Do any of your blood relations have problems with the following? Check any that apply:**

( ) Asthma ( ) Diabetes ( ) Tuberculosis ( ) High Blood Pressure ( ) Stroke ( ) Headaches ( ) Hearing loss...  
( ) Heart disease ( ) Allergies ( ) Cancer ( ) Thyroid disease ( ) Bleeding problems ( ) Problems with Anesthesia  
( ) Autoimmune disease

**PAST MEDICAL HISTORY:**

Have you ever been diagnosed with cancer? ( ) NO ( ) YES Please give details: \_\_\_\_\_

**DO YOU HAVE PROBLEMS WITH ANY OF THE FOLLOWING? PLEASE CHECK ( ) THOSE THAT APPLY**

**GENERAL** NO ( ) Fever ( ) Weight Change ( ) Fatigue  
**EYES** NO ( ) Visual loss ( ) Glaucoma ( ) Cataracts ( ) Itchy Eyes ( ) Tearing ( ) Blurred vision  
**EARS** NO ( ) Vertigo ( ) Dizziness ( ) Ringing Noises ( ) Hearing Loss ( ) Hearing Aid ( ) Infections ( ) Trauma ( ) Noise Exposure ( ) Ear ache ( ) Drainage  
**NOSE** NO ( ) Discharge ( ) Clear ( ) colored ( ) thick ( ) thin ( ) post nasal drip ( ) obstruction ( ) Bleeding ( ) Sneezing  
**MOUTH** NO ( ) Lumps ( ) Dental problems ( ) Tonsillitis ( ) Mouth sores  
**THROAT** NO ( ) Hoarseness ( ) Voice Change ( ) Problem Swallowing ( ) Pain  
**NECK** NO ( ) Pain ( ) Lumps ( ) Thyroid Nodules ( ) Swollen glands  
**SKIN** NO ( ) Breast Lumps ( ) Psoriasis ( ) Skin Growths ( ) Rash ( ) Itching  
**LUNGS** NO ( ) Wheezing ( ) Asthma ( ) COPD ( ) Bronchitis ( ) Emphysema ( ) Coughing up blood ( ) Chronic Cough ( ) Pneumonia ( ) Positive TB Test ( ) Shortness of breath  
**SLEEPING** NO ( ) Snoring ( ) Apnea ( ) Insomnia ( ) Waking up tired ( ) Daytime Tiredness  
**HEART** NO ( ) High Blood Pressure ( ) Coronary heart disease ( ) Myocardial infarction ( ) Chest Pain ( ) Mitral Valve Collapse ( ) Congestive Heart Failure ( ) Heart Valve Disease ( ) Angina ( ) Murmurs ( ) Rheumatic Fever  
**GASTRO-INTESTINAL** NO ( ) Hiatal Hernia ( ) Heartburn ( ) Reflux ( ) Rectal Bleeding ( ) Ulcers ( ) Hepatitis Type ( ) Jaundice ( ) Nausea ( ) Vomiting ( ) Colitis  
**GENITO-URINARY** NO ( ) frequent urination ( ) Pain ( ) Discharge ( ) Incontinence ( ) Bloody Urine  
**MEN:** ( ) Prostrate problem ( ) Hernias  
**WOMEN:** ( ) Abnormal periods ( ) menopause ( ) Are you Pregnant? ( ) Y ( ) N  
**MUSCLE / JOINTS** NO ( ) Muscle Pain ( ) back Pain ( ) Joint Pain ( ) Arthritis ( ) Lupus ( ) Gout  
**NEUROLOGICAL** NO ( ) Headaches ( ) Migraines ( ) Imbalance ( ) Alzheimer's Disease ( ) loss of Consciousness ( ) Parkinson's Disease ( ) Head Trauma ( ) Tremors ( ) Fainting ( ) Seizures ( ) TIA's ( ) Stroke  
**PSYCHIATRIC** NO ( ) Nervousness ( ) Anxiety ( ) Depression ( ) Mood Swings  
**ENDOCRINE** NO ( ) Thyroid Disease ( ) Diabetes ( ) Glandular / Hormonal Problems  
**HEMATOLOGIC** NO ( ) Slow to heal after cuts ( ) Easy Bruising or bleeding ( ) Immunocompromised status ( ) Transfusions ( ) Phlebitis ( ) Anemia

If this form is filled out by anyone other than the patient, please write the name and relationship.

NAME: \_\_\_\_\_ RELATIONSHIP TO PATIENT \_\_\_\_\_

I certify that this information is true and correct to the best of my knowledge. I will notify you if any changes occur

SIGNATURE: \_\_\_\_\_ DATE \_\_\_\_\_

I have reviewed the above information with the patient: MD SIGNATURE: \_\_\_\_\_

Sleep Multimedia

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Name: \_\_\_\_\_ Age: \_\_\_\_\_

Today's Date: \_\_\_\_\_ Male/Female: \_\_\_\_\_

How likely are you to doze or fall asleep in the following situations. In contrast to feeling tired? This refers to your usual way of life in recent times. Even if you have not done some of these things recently try to work out how they would have affected you. Use the following scale to choose the *most appropriate number* for each situation :

- 0 = would never doze
- 1 = *slight* chance of dozing
- 2 = *moderate* chance of dozing
- 3 = *high* chance of dozing

**SITUATION**

**CHANCE OF DOZING**

Sitting and Reading \_\_\_\_\_

Watching TV \_\_\_\_\_

Sitting inactive in a public place  
(e.g. a movie theatre/ meeting) \_\_\_\_\_

As a passenger in a car for an hour without a break  
\_\_\_\_\_

Lying down to rest in the afternoon  
when circumstances permit \_\_\_\_\_

Sitting and talking to someone \_\_\_\_\_

Sitting quietly after lunch without alcohol \_\_\_\_\_

In a car while stopped for a few minutes  
in traffic \_\_\_\_\_