NEW PATIENT
SLEEP HEALTH HISTORY

PALOMAR HEALTH Medical Group

Patient Name:_____

Date of Birth: _____ Date: _____

PCP Name:_____

PCP Phone Number:_____PCP Fax Number:_____

Referred By:_____

What is your primary sleep problem?_____

Average time asleep nightly (hrs):_____Average Number of nighttime awakenings:_____

Height: _____ Weight:_____ If known, Neck/Collar size: _____inches_____

Current Medications (please include dose and frequency and time of day taken):

_____

_____

_____

_____

Pharmacy (name and address):_____

Serious Drug Allergies (not food):_____

Have you ever had a sleep study? Yes or No

If Yes, list when and where of all prior sleep studies and whether your test completed at home or in a facility and the name of the company (please provide us with copies):

_____

If you have Sleep Apnea:

Current form of treatment (CPAP/other device) and Current Pressure Settings (if known):

_____

Type of Mask and equipment details (nasal pillows, under the nose, nasal, or full face mask):

_____

Current DME company for Mask/PAP Supplies:_____

MEDICAL HISTORY (Please list year diagnosed)

☐ No Pertinent Medical History	☐ Hypertension/Blood Pressure	**PSYCHIATRIC HISTORY** Please list year diagnosed
☐ Obstructive Sleep Apnea	☐ Heart Disease/Heart Attack	☐ Obsessive Compulsive Disorder (OCD)
☐ Central Sleep Apnea/Mixed	☐ Thyroid Disease	☐ Anxiety disorder ☐ Depressive disorder
☐ Chronic Insomnia	☐ Anemia ☐ Polycythemia	☐ Bipolar disorder
☐ Narcolepsy with Cataplexy	☐ Kidney disease ☐ Liver disease	☐ Schizophrenia
☐ Narcolepsy without Cataplexy	☐ COPD	☐ Attention deficit-hyperactivity disorder
☐ Idiopathic Hypersomnia	☐ Asthma	☐ Eating Disorders
☐ Restless Leg Syndrome ☐ Peripheral Neuropathy	☐ Multiple Sclerosis	☐ Alcohol/drug dependence (current)
☐ REM Behavior Disorder	☐ Fibromyalgia	☐ Alcohol dependence (past)
☐ Chronic Fatigue Syndrome	☐ Seizure Disorder	☐ Drug dependence (past)
☐ Chronic Back Pain	☐ Parkinson's Disease	☐ Inpatient hospitalization
☐ Chronic Joint Pain	☐ Alzheimer's Disease/Other Dementia	☐ History of suicide attempt
☐ Chronic pain disorder	☐ Stroke/TIA	
☐ Atrial fibrillation	☐ Migraine headache ☐ TMJ	
☐ Other cardiac arrhythmias	**MALES**	Other Pertinent Medical History (Please List)
☐ Congestive Heart Failure	☐ BPH/Large prostate	
☐ GERD/Heartburn	☐ Erectile Dysfunction /Impotence	
☐ Diabetes Mellitus	**FEMALES**	
☐ Allergic rhinitis (nasal allergies)	☐ Menopause	
☐ Seasonal/Environmental Allergies	☐ Urinary Incontinence	

SURGICAL HISTORY (Please list year of Surgery)

☐ No prior surgeries	☐ Other ENT (Nose/Throat) Surgeries	☐ Pacemaker/AICD implantation
☐ Tonsils/Adenoids removed	☐ Jaw Surgeries	☐ Bariatric Surgery
☐ Surgery for sleep apnea/UPPP/INSPIRE	☐ Orthodontia/Braces	☐ Back Surgery ☐ Neck Surgery
☐ Nasal Turbinate Reduction	☐ Coronary artery bypass	☐ Other Pertinent Surgery
☐ Deviated nasal septum surgery ☐ Sinus surgery	☐ Cardiac angioplasty/stents ☐ Cardiac Ablation	

FAMILY HISTORY Any Family members diagnosed with the following?

FAMILY MEMBER	Sleep Apnea	Narcolepsy	Insomnia	Restless Leg Syndrome	Depression/ Anxiety	Parkinson's Disease	Other Pertinent sleep disorders Please list
Father							
Mother							
Sister							
Brother							
Grandparents							
Children							