SLEEP MEDICINE SPECIALISTS OF SOUTH FLORIDA

Date: _____

Patient Name: _____ ***DOB:***_____

Sex: ○Male ○Female ***If female, are you pregnant?*** ○Yes ○No

Chief Complaint/Reason for visit: _____

Current Medications (please include over the counter medications, herbals, and vitamins):

_____

_____

_____

Past surgeries, major medical events/hospitalizations: _____

_____

Allergies: ○None _____

Past Medical History (ongoing chronic medical problems): _____

_____

_____

Family History: Dad: _____ ***Mom:*** _____

Siblings: _____

Social History: ***Caffeine (Type/Amount – include coffee, sodas, tea and energy drinks):*** _____

_____

_____

Alcohol (Type/Amount): _____

Tobacco: Lifetime non-smoker? ○Yes ○No

If former smoker: How many packs per day? _____ ***How many years?*** _____
What year did you quit? _____

If current smoker: How many packs per day? _____ ***How many years?*** _____

Pre-bedtime activities: _____

Work schedule (Days of week and time): _____

Exercise (times/week, time/session): _____

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