Pulmonary and Sleep Medicine Consultants

Accredited by the American Academy of Sleep Medicine (AASM)

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New Patient Questionnaire

Name: _____ **Date**: _____

DOB: _____ Age: _____

Sex (*circle one*): M F

Referring Physician: _____

Height: (ft/in) _____

Weight (lb) _____

Vitals: *(please leave blank)*

HT: _____
WT: _____
B/P: _____
O2: _____
P: _____

Clinical History

Past Medical History: *(Circle if applicable)*

Diabetes	Controlled/Uncontrolled
Chest Pain	Controlled/Uncontrolled
Acid Reflux	Controlled/Uncontrolled
Bladder Problems	Controlled/Uncontrolled

Family History: DM/HTN/CAD/Stroke/Cancer

Do you currently have symptoms of:
(Circle Yes or No)

Hypertension Y/N Controlled/Uncontrolled

Excessive Daytime Sleepiness Y/N
If yes, have you ever:
Lost control while driving? Y/N
Fallen asleep at the wheel? Y/N

Circle Yes or No:

Mood Disorders	Y/N
Insomnia	Y/N
Ischemic Heart Disease	Y/N
History of Stroke	Y/N
Hyperlipidemia	Y/N
Cardiac History	Y/N

Medications

Please list all current medications and dosage:

_____
_____
_____
_____
_____

Allergies? YES NO

_____

Past Surgical Procedures:

Please list any below:

_____
_____
_____

Social History:

Do you smoke? YES NO

How much tea, coffee, soda, or alcohol do you drink per day? _____

Pharmacy/Address/Phone Number: