

Patient Name: \_\_\_\_\_ Chart #: \_\_\_\_\_

Referring Physician: \_\_\_\_\_ Today's Date: \_\_\_\_\_

**PAST MEDICAL HISTORY**

Have you ever been hospitalized or had Surgery? If so, please list date(s) of hospitalization and/or surgeries.	Location of Hospitalization and/or Surgery.	Reason for Hospitalization or Surgery.
1		
2		
3		
4		
5		

Do you have any other medical conditions not listed or described above? Please describe:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**SOCIAL HISTORY**

**Occupation:**  Retired  Homemaker  Employed – current occupation(s): \_\_\_\_\_

**Have you used any of the following substances?**

Substance	Currently Use?	Previously Used?	Type/Amount/ Frequency	How Long? (years)	If stopped, when? (year)
Caffeine: coffee, tea, soda	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No			
Alcohol: beer, wine, liquor	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No			
Recreational/Street Drugs	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No			
Smoke cigarettes	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No			

Do you snore?  Yes  No

Are you excessively tired on awakening?  Yes  No

Do others notice that you stop breathing during sleep?  Yes  No

Do you feel you must take naps during the day?  Yes  No

**SYSTEMS REVIEW**

Indicate whether you have experienced the following symptoms during recent months by checking (✓) the corresponding box:

<input type="checkbox"/> Fever	<input type="checkbox"/> Chills	<input type="checkbox"/> Sweating	<input type="checkbox"/> Cough	<input type="checkbox"/> Asthma
<input type="checkbox"/> Sleep Apnea	<input type="checkbox"/> Nausea	<input type="checkbox"/> Vomiting	<input type="checkbox"/> Abdominal pain	<input type="checkbox"/> Diarrhea
<input type="checkbox"/> Constipation	<input type="checkbox"/> Urination pain	<input type="checkbox"/> Wheezing	<input type="checkbox"/> Depression	<input type="checkbox"/> Snoring
<input type="checkbox"/> Unusual stress	<input type="checkbox"/> Anxious/Angry	<input type="checkbox"/> Unusual weight loss	<input type="checkbox"/> Unusual weight gain	<input type="checkbox"/> Anemia
<input type="checkbox"/> Bleeding from bowels	<input type="checkbox"/> Bleeding from nose or gums	<input type="checkbox"/> Excess thirst or urination	<input type="checkbox"/> Enlarged lymph nodes	<input type="checkbox"/> Black or bloody stools
<input type="checkbox"/> Pain, stiffness, or swelling in back, joints or muscles	<input type="checkbox"/> Stroke or mini stroke (TIA)	<input type="checkbox"/> Weakness or slurred speech	<input type="checkbox"/> Blurred or double vision	<input type="checkbox"/> Difficulty starting urination

Physician Review Signature: \_\_\_\_\_ Date: \_\_\_\_\_