

Medical History

- 1) Height _____ inches 2) Weight _____ lbs 3) Last physical exam (year)? _____
- 4) In the last 12 months how many pounds have you (circle appropriate term) gained or lost? _____
 In the last 3 months how many pounds have you (circle appropriate term) gained or lost? _____
- 5) Do you currently use tobacco products? yes no
 If no, but you used tobacco in the past, how long has it been since you stopped? _____
 How many (circle type of usage) cigarettes, cigars, tins or pipefuls of tobacco do (did) you use daily? _____
 For how many years did (have) you used tobacco? _____
- 6) **Briefly list below the health problems you have had and their treatment:**

System	Type of Problem/Treatment	Date	Treating Physician, Clinic, or Hospital
Respiratory conditions (asthma, COPD, etc.)			
Eyes, ears, nose, throat/mouth (glaucoma, sinus, obstruction, allergies, surgery, etc.)			
Heart, circulation, blood pressure			
Stomach, digestive disorders			
Kidney, urological or sexual disorders			
Head/nervous system (e.g. head trauma, convulsions)			
Psychological or psychiatric			
Accidents/injuries (e.g. bone fracture, dislocations)			
Surgical operations (e.g. tonsillectomy, nasal surgery, hysterectomy, etc.)			
Other conditions (e.g. painful conditions, hormone abnormalities, diabetes, thyroid, etc.)			

7) **List the amounts of the following beverages you consume.** If not used daily, list in the far right column the average per week.

Beverages	Daily	After 6:00 pm	Weekly
Cups of coffee			
Decaffeinated coffee (cups)			
Tea (glasses or cups)			
Carbonated drinks (cans/bottles)			
Beer, wine, liquor (cans/drinks)			
Recreational drugs (list below)			

8a) List all medications (prescribed by a doctor, non-prescribed, or over the counter) ever taken for your Sleep Problems.

Medications for Sleep	Dose	Times Daily	Helpful?	How Long Used?	Use It Now?	When Stopped?	Prescribing Doctor

8b) Apart from the sleep medicines listed above, name all other medications you are currently taking (prescribed or otherwise).

Current Medication(s)	Dose	Times Daily	Reason	How Long Used?	Prescribing Doctor

9) Family Health History: For each family member, write current age and present state of health (good, fair, poor) or age at death and cause of death, as well as sleep problems (snoring, insomnia, sleepiness, etc.) and major illnesses.

Relationship	If Living, Age/ Health	If Deceased, Age/ Cause	Sleep or Medical Problems
Father			
Mother			
Spouse			
Brother(s)			
Sister(s)			
Children			

10) Treating Physicians

List name, address, and phone number of primary care physician.	List name, address, and phone number of treating physician (if not your primary care physician).

Please attach any additional comments that you may wish to make about your health, intake of drugs, medicines, or alcohol.