

Health History (CONFIDENTIAL)

Date: _____

Kirk G. Watkins, M.D. - Medical Director | Mark C. Boyer, FNP

Name: _____ Date of Birth: _____

Referring Physician: _____ Primary Physician: _____

Other Physician to whom reports should be sent: _____

My bed partner has told me I stop breathing during sleep. YES NO

I have the following sleep symptoms: Check (✓) symptoms you currently have or have had in the past year.

	YES	NO		YES	NO		YES	NO
Loud snoring	<input type="checkbox"/>	<input type="checkbox"/>	Heartburn awakenings	<input type="checkbox"/>	<input type="checkbox"/>	Restless legs	<input type="checkbox"/>	<input type="checkbox"/>
Daytime Sleepiness	<input type="checkbox"/>	<input type="checkbox"/>	Bathroom awakenings	<input type="checkbox"/>	<input type="checkbox"/>	Bedtime leg discomfort	<input type="checkbox"/>	<input type="checkbox"/>
Daytime fatigue	<input type="checkbox"/>	<input type="checkbox"/>	Dry mouth awakenings	<input type="checkbox"/>	<input type="checkbox"/>	Leg cramps	<input type="checkbox"/>	<input type="checkbox"/>
Snore awakenings	<input type="checkbox"/>	<input type="checkbox"/>	Restless sleep	<input type="checkbox"/>	<input type="checkbox"/>	Sleep talking	<input type="checkbox"/>	<input type="checkbox"/>
Choking awakenings	<input type="checkbox"/>	<input type="checkbox"/>	Unrefreshing sleep	<input type="checkbox"/>	<input type="checkbox"/>	Sleepwalking	<input type="checkbox"/>	<input type="checkbox"/>
Gasp awakenings	<input type="checkbox"/>	<input type="checkbox"/>	Morning headaches	<input type="checkbox"/>	<input type="checkbox"/>	Teeth grinding	<input type="checkbox"/>	<input type="checkbox"/>
						History of seizures	<input type="checkbox"/>	<input type="checkbox"/>

I have the following medical conditions:

	YES	NO		YES	NO
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Stomach Ulcers	<input type="checkbox"/>	<input type="checkbox"/>
Coronary Artery Disease	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	Migraine Headaches	<input type="checkbox"/>	<input type="checkbox"/>
Low thyroid	<input type="checkbox"/>	<input type="checkbox"/>	Cardiac Arrhythmia	<input type="checkbox"/>	<input type="checkbox"/>
History of Stroke	<input type="checkbox"/>	<input type="checkbox"/>	Depression	<input type="checkbox"/>	<input type="checkbox"/>
Heartburn	<input type="checkbox"/>	<input type="checkbox"/>	Anxiety Disorder	<input type="checkbox"/>	<input type="checkbox"/>

Have had the following surgeries:

	YES	NO
Tonsillectomy	<input type="checkbox"/>	<input type="checkbox"/>
Hysterectomy	<input type="checkbox"/>	<input type="checkbox"/>

If you mark Yes for any of the following, a copy must be provided for us to honor your wishes

Yes	No	Copy Requested
<input type="checkbox"/>	<input type="checkbox"/>	Do You Have A Living Will? <input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Do You Have A Durable/ Special Power of Attorney? <input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Do You Have A Medical Treatment Plan? <input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Would You Like More Information? <input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Do you have a Physician Order for Life Sustaining Treatment (POLST)? <input type="checkbox"/>

Patients Signature

Practitioners Signature

Other Medical Conditions:

I take the following medications, including vitamins & herbals:

Do you use: YES NO YES NO YES NO YES NO

Tobacco? Alcohol? Caffeine? Recreat'l Drugs?

How much?

Family history

Snoring	_____	Obstructive sleep apnea	_____
Other sleep disorders	_____	High blood pressure	_____
Heart disease	_____	Heart attacks	_____
Stroke	_____	Diabetes	_____
Low thyroid	_____		

Do you suffer from any of the following: Check (✓) all that apply.

	YES	NO		YES	NO		YES	NO
Non-migraine headaches	<input type="checkbox"/>	<input type="checkbox"/>	Persistent nausea	<input type="checkbox"/>	<input type="checkbox"/>	Menstrual difficulties	<input type="checkbox"/>	<input type="checkbox"/>
Hay fever or allergies	<input type="checkbox"/>	<input type="checkbox"/>	Persistent vomiting	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Chronic sinus congestion	<input type="checkbox"/>	<input type="checkbox"/>	Persistent diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	Chronic back pain	<input type="checkbox"/>	<input type="checkbox"/>
Chest pain	<input type="checkbox"/>	<input type="checkbox"/>	Persistent constipation	<input type="checkbox"/>	<input type="checkbox"/>	Chronic neck pain	<input type="checkbox"/>	<input type="checkbox"/>
Heart palpitations	<input type="checkbox"/>	<input type="checkbox"/>	Bladder problems	<input type="checkbox"/>	<input type="checkbox"/>	Skin disorders	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>	Prostate problems	<input type="checkbox"/>	<input type="checkbox"/>	Panic attacks	<input type="checkbox"/>	<input type="checkbox"/>
						Swelling of ankles	<input type="checkbox"/>	<input type="checkbox"/>