

**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:**
**Have had the following surgeries:**

	YES	NO		YES	NO		YES	NO
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Stomach Ulcers	<input type="checkbox"/>	<input type="checkbox"/>	Tonsillectomy	<input type="checkbox"/>	<input type="checkbox"/>
Coronary Artery Disease	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Hysterectomy	<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"/>			

**Other Medical Conditions:**

\_\_\_\_\_

**I take the following medications, including vitamins and herbal preparations:**

 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

	YES	NO		YES	NO		YES	NO		YES	NO
<b>Do you use tobacco?</b>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Alcohol?</b>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Caffeine?</b>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Recreat'l Drugs</b>	<input type="checkbox"/>	<input type="checkbox"/>
How much			How much			How much			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"/>