



**Desert Pulmonary & Sleep Consultants**  
**2730 S. Val Vista Dr. Gilbert, Arizona 85295**

**Patient History Questionnaire for Sleep Disorders Evaluation**

NAME \_\_\_\_\_

DATE \_\_\_\_\_

My Main Sleep Problem Is:

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**MEDICAL HISTORY**

Have you ever had...?	If yes, please explain.	
Arthritis	YES	NO _____
Asthma	YES	NO _____
Back Problems	YES	NO _____
Diabetes	YES	NO _____
Heart Disease	YES	NO _____
High Blood Pressure	YES	NO _____
Restless Legs	YES	NO _____
Sexual Problems	YES	NO _____
Sleep Apnea	YES	NO _____
Stroke	YES	NO _____
Thyroid Disease	YES	NO _____
Urinary Trouble	YES	NO _____
Other Medical Illnesses	YES	NO _____

**SURGICAL HISTORY**

Adenoids	YES	NO _____
Tonsils	YES	NO _____
Thyroid	YES	NO _____
Back	YES	NO _____
Nose	YES	NO _____
Jaw	YES	NO _____
Lung	YES	NO _____
Heart	YES	NO _____
Other Surgeries	YES	NO _____

**FAMILY HISTORY**

Any Blood Relative With...?		
Sleep Apnea	YES	NO _____
Narcolepsy	YES	NO _____
Sleep Problems	YES	NO _____
Thyroid Disease	YES	NO _____
Obesity	YES	NO _____
Heart Disease	YES	NO _____
High Blood Pressure	YES	NO _____
Snoring	YES	NO _____

**CURRENT MEDICATIONS**

Please List Medicines and Dosages

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

**ALLERGIES TO MEDICATION**

\_\_\_\_\_

**SOCIAL HISTORY**

If Yes, Please Specify

Do you smoke? \_\_\_\_\_

Do you drink alcohol? \_\_\_\_\_

Do you drink coffee? \_\_\_\_\_

Do you drink caffeinated soft drinks/iced tea? \_\_\_\_\_

Marital Status        M     D     W     S

Occupation? \_\_\_\_\_

Any shift work? \_\_\_\_\_

**THANK YOU**