

Patient Information

Date _____

Name _____ Age _____ Date of Birth _____ Race _____
Last First Middle

Marital Status: single married other _____ Employed: Yes | No Student: full-time part-time

Sex: male female Social Security # _____ Drivers License # /State _____

Mailing Address _____ APT# _____ Email _____

City / State / Zip _____

Phone: Home # _____ Work # _____ other # _____ Employer _____

Position _____ Employer's Address _____
PO Box/Street City/State/ZIP

Nearest Relative Not Living With You _____ Phone # _____ Relationship _____

Emergency Contact: _____ Phone #1 _____ Phone #2 _____

Allergies (list all): _____

Special Needs (list all): _____

Primary Doctor _____ Cardiologist _____ Other _____

PLEASE CHECK YES OR NO TO ALL THAT APPLY:

- | | | | |
|----------------------------------|--|---|--|
| Do you have high blood pressure? | <input type="checkbox"/> Yes <input type="checkbox"/> No | Are you handicapped? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Excessive Daytime Sleepiness? | <input type="checkbox"/> Yes <input type="checkbox"/> No | Do you require assistance with daily activities? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Do you experience insomnia? | <input type="checkbox"/> Yes <input type="checkbox"/> No | Have you ever had a Seizure? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Difficulty thinking/remembering? | <input type="checkbox"/> Yes <input type="checkbox"/> No | Do you use Oxygen? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Have you ever had a stroke? | <input type="checkbox"/> Yes <input type="checkbox"/> No | Do you have a communicable disease? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Do you have heart disease? | <input type="checkbox"/> Yes <input type="checkbox"/> No | Have you had a sleep study? (If yes, when & where?) | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Do you have a mood disorder? | <input type="checkbox"/> Yes <input type="checkbox"/> No | | |

GUARDIAN/PARENT INFORMATION (If patient is under 18) Spouse | Mother | Father | Guardian | Other _____

Name _____ Social Security # _____ DOB _____ Employer _____

Address _____ Phone: work # _____ other # _____



PLEASE FILL OUT THE BACK OF THIS FORM

