History & Physical Information

Date: _____ **Name:** _____

Sleep	☐ EDS	☐ Snoring	☐ Witnessed Apneas
	☐ Insomnia	☐ Nocturia	☐ Frequent Awakenings
Physical	☐ Obesity	☐ Enlarged Tonsils	☐ Reduced Mobility
	☐ Reduced Dexterity	☐ High Arched Palate	☐ Weight Loss/Gain
	☐ Chronic Pain	☐ Fibromyalgia	☐ GERD
	☐ Anxiety	☐ Depression	☐ Diabetes
Parasomnias	☐ PLMD	☐ Sleep Walking	☐ Sleep Talking
	☐ Night Terrors	☐ Nightmares	☐ RBD
Pulmonary	☐ COPD	☐ Asthma	☐ CSA
	☐ O2 use	☐ Tracheostomy	☐ OHS
Neuro	☐ Seizures	☐ Stroke	☐ ADHD
	☐ Spina Bifida	☐ ALS	☐ Migraines
Cardiac	☐ CHF	☐ AFib	☐ Heart Attack
	☐ Pacemaker	☐ HBP	☐ Arrhythmias
PAP	☐ CPAP use	☐ BIPAP use	☐ Could not tolerate PAP

Current PAP settings _____

Other Concerns _____

_____

Neck Circumference _____ **Height** _____ **Weight** _____

Food/Drug Allergies: _____

Medications: _____ _____

_____ _____

_____ _____

_____ _____

Patient /Parent 's Signature: _____