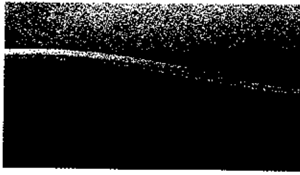

Health History

Please provide your medical history by completing the following information.

Are you allergic to any medication?________________________________

Do you have, or have you ever had, any of the following? Please **circle** your answer(s).

Abrupt awakenings	Daytime sleepiness	Mitral Valve Prolapse
Alcoholism	Diabetes 1 2	Neck & Back problems
Allergies	Dry Mouth	Nervous problems/disorders
Allergies to medication	Excessive Bleeding	Pacemaker
Allergies to metals	Glaucoma	Radiation treatment
Anemia	GERD	Respiratory problems
Arthritis	Hearing impaired	Restless leg syndrome
Asthma	Heart disease	Seizures/fainting spells
Atrial Fibrillation	Heart valve, murmur	Sinus problems
Blood disease	Hepatitis/Liver disease	Sleep Apena
Bone disease	High Blood Pressure	Snoring
Cancer	Hip or Joint replacement	Sore throat
Chest pain	HIV	Stomach Ulcers
Circulatory problems	Kidney disease	Stroke
Congestive Heart Failure	Latex Sensitivity	Thyroid disease
Use a CPAP	Lupus	Tuberculosis

Please list all medications, including over the counter (aspirin, vitamins, herbs, etc.) you take:___

____

____

Patient Signature:____Date:______________