ENT & SLEEP SPECIALISTS

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Patient Name: _____ **Date:** ____/____/____

DOB: _____ **Height (ft/in):** _____ **Weight (lbs):** _____ **Neck Size (in):** _____

Chief Complaint/Reason for your visit:

_____
_____
_____
_____ _____
_____ _____
_____ _____

Medications, including dose and frequency:

_____
_____
_____
_____ _____
_____ _____

Do you have any allergies to medication? _____ Yes _____ No

- If yes, which ones? _____

Past Medical History (i.e. high blood pressure, diabetes, high cholesterol, cancer, etc)

_____
_____
_____
_____ _____

Do you have any seasonal allergies? _____ Yes _____ No

Any surgical or medical hospitalizations in the past 10 years? _____ Yes _____ No

- If so, please specify: _____

Family Medical History (i.e. hypertension, heart disease, diabetes, cancer, etc.)

_____
_____
_____

Do you smoke? _____ Yes _____ No

- If yes, how many packs per day? _____ Packs
- If yes, did you quit smoking? _____ Yes _____ No
  -If yes, how long ago did you quit smoking? _____ Months _____ Years

Do you drink alcohol? _____ Yes _____ No

- If yes, how many glasses per week? _____ Glasses