Name:_____ Date:_____

Sleep-Related Medical History Please answer the following questions as best as possible. Dates may be approximated, e.g. "1970s."

	Yes	No
1) Are you Left- Handed?	☐	☐
2) Did you have your tonsils removed?	☐	☐
If yes, when? _____		
3) Do you have problems with nasal stuffiness?	☐	☐
If yes, is it seasonal?	☐	☐
If yes, is it associated with allergies?	☐	☐
4) Have you had allergy testing?	☐	☐
If yes, when was it? _____		
If yes, who was your allergist? _____		
5) Do you have nasal stuffiness all year?	☐	☐
6) Have you had a nasal fracture?	☐	☐
If yes, what year? _____		
7) Have you had nose or sinus surgery?	☐	☐
If known, please list the year _____		
Surgeon, _____ Procedure_____		
8) Have you had a head injury associated with laceration, Concussion, or loss of consciousness?	☐	☐
If yes, when? _____		
If you were unconscious, how long were you unconscious?____		

Name: _____ Date: _____

	Yes	No
9) Have you ever fainted or passed out?	☐	☐
If yes, when? _____		
10) Have you ever had a seizure?	☐	☐
11) Have you ever been iron deficient?	☐	☐
12) Do you have to wake up every night to urinate?	☐	☐
If yes, how many times on average? _____		
13) Do you have any problems with decreased libido or sexual drive?	☐	☐
14) Do you have any problems with erectile dysfunction?	☐	☐
15) Has your shoe size changed in adulthood?	☐	☐
16) Are you now at your maximal weight?	☐	☐

If not, what was your maximal weight? _____

How old were you at your maximal weight? _____

How much did you weigh at age 18? _____

If you snore, how old were you when you were first told you snored? ___

If you are sleepy, how long have you had excessive sleepiness? _____

If you drink regular coffee or tea, how many cups a day do you drink? ___

If you drink caffeinated soda, how many cans or bottles do you drink daily? _____

17) Other Surgical procedures not listed:_____
_____

18) Family History of: Diabetes ☐ Heart Disease ☐ Thyroid ☐