QUESTIONNAIRE FOR NEW PATIENTS

Patient's Name: ______________________ **Date:** __________________

1. **Do you have any significant past medical or surgical history? For example *diabetes, heart failure* etc. Please list:**

   ____
   ____
   ____
   ____

2. **Please list names and dosage of present medications including inhalers.**

   ____
   ____
   ____
   ____

3. **Any allergies? Please list:**

   ____
   ____
   ____

4. **a) Do you smoke? Please check appropriate answer: YES _____ NO _____**
   b) If no, have you ever smoked? YES _____ NO _____
   c) If you are a current or ex-smoker how many years total did you smoke and how many packs per day on average?

   ____
   ____

5. **How many beverages on average do you drink a day?**
   _____ caffeinated coffee **_____ caffeinated tea**
   _____ caffeinated soda **_____ Alcoholic beverages**

6. **Please list past and present occupations:**

   ____
   ____
   ____
   ____

7. **Please list family history of sleep apnea of other medical illnesses:**

   ____
   ____
   ____
   ____

Thank you very much. Malvern Sleep Clinic