
# Patient Information and Medical History

Patient Name: _____

Social Security Number: _____

Date of Birth: _____/_____/_____

Chief Complaint:

_____

How did you hear about us? _____

**PERSONAL INFORMATION**

Address:

_____

_____

Phone:

❑ Mobile ❑ Home _____

If cell, okay to text? ❑ Yes ❑ No

Email:

_____


Occupation:

_____

Employer/Company Name (optional):

_____

Phone:

_____

Okay to contact you at this number? ❑ Yes ❑ No

Emergency Contact:

Name _____

Phone _____

Relationship _____


**INSURANCE**

*ARE YOU THE SUBSCRIBER? ❑ Yes ❑ No*

*(IF NO) SUBSCRIBER NAME:*_____

*SUBSCRIBER DOB:* _____

*Medical Insurance:*

Carrier _____

Member ID _____

Group ID _____

Group Name _____

Insurance Phone _____

*Dental Insurance:*

Carrier _____

Member ID _____

Group ID _____

Group Name _____

Insurance Phone _____


**MEDICAL HISTORY**

Medications (including prescription and over-the-counter):

_____
_____
_____
_____
_____
_____
_____
_____

Do you have any allergies to any medications? ❑ Yes ❑ No If yes – please list:

_____
_____

Past Surgical History:

_____
_____
_____
_____
_____
_____
_____
_____

Have you ever had your tonsils and/or adenoids surgically removed? ❑ Yes ❑ No


**SOCIAL HISTORY:**

Caffeine:

_____ # of cups of coffee per day

_____# of cups of tea per day

_____ # cans or glasses of soda per day

_____# of servings of chocolate per week

_____# of energy drinks per day

Alcohol:

❑ None ❑ Yes _____ # of drinks per week

Tobacco:

❑ None

❑ Yes _____ # of cigarette packs per day _____ # of years

Recreational Drugs (such as marijuana or cocaine):

❑ None ❑ Yes If yes, which ones?

_____
_____

Marital Status:

❑ Married ❑ Single ❑ Divorced ❑ Widowed

Children:

❑ No ❑ Yes How many? _____

Pets: ❑ No

❑ Yes How many? _____

What type of pet(s)?

_____
_____

Do you have any children or pets that sleep in your bedroom? ❑ No ❑ Yes

**REVIEW OF SYMPTOMS:**

Respiratory:

Cough ❑ Yes ❑ No

Asthma ❑ Yes ❑ No

Wheezing ❑ Yes ❑ No

Poor Exercise Tolerance ❑ Yes ❑ No

Genitourinary:

Bed Wetting ❑ Yes ❑ No

Frequent Urination ❑ Yes ❑ No

Difficulty Urinating ❑ Yes ❑ No

Blood in Urine Yes ❑ No

# THRIVE
## SLEEP & BREATHING

Constitutional:

Loss of Appetite ❑ Yes ❑ No

Sweats Fever ❑ Yes ❑ No

Fatigue ❑ Yes ❑ No

Weight Gain ❑ Yes No ❑

Weight Loss ❑ Yes ❑ No

Gastrointestinal:

GERD ❑ Yes ❑ No

Heartburn/Indigestion❑ Yes ❑ No

Black or Bloody Stools❑ Yes ❑ No

Diarrhea ❑ Yes ❑ No

Nausea/Vomiting ❑ Yes ❑ No

Jaundice ❑ Yes ❑ No

Abdominal Pain ❑ Yes ❑ No

Erectile dysfunction ❑ Yes ❑ No ❑

Musculoskeletal:

Stiff/Sore Joints ❑ Yes ❑

No Muscle Pain ❑ Yes ❑ No

Red or Swollen Joints ❑ Yes ❑ No

Temporomandibular Joint (TMJ) pain/jaw discomfort ❑ Yes ❑ No

Ears/Nose/Throat/Mouth:

Hearing Loss ❑ Yes ❑ No

Sore Throat ❑ Yes ❑ No

Sinus Congestion ❑ Yes ❑ No

Hoarseness ❑ Yes ❑ No

Neurologic:

Weakness ❑ Yes ❑ No

Seizures ❑ Yes ❑ No

Involuntary Tongue Biting ❑ Yes ❑ No

Passing Out ❑ Yes ❑ No

Dizziness ❑ Yes ❑ No

Headaches ❑ Yes ❑ No

Numbness ❑ Yes ❑ No

Restless Leg Syndrome ❑ Yes ❑ No


Psych:

Excessive Stress ❑ Yes ❑ No

Memory Loss: ❑ Yes ❑ No

Difficulty with Focus ❑ Yes ❑ No

Trouble Concentrating ❑ Yes ❑ No

Hallucinations ❑ Yes ❑ No

Nervousness or Anxiety ❑ Yes ❑ No

Allergy/Immunology:

Sneezing ❑ Yes ❑ No

Runny Nose ❑ Yes ❑ No

Hives ❑ Yes ❑ No

Itchy Eyes or Nose ❑ Yes ❑ No

Nasal allergies/Hay fever ❑ Yes ❑ No

Nasal Congestion ❑ Yes ❑ No

Eyes:

Blurry Vision❑ Yes ❑ No

Double Vision❑ Yes ❑ No

Vision Loss ❑ Yes ❑ No

Cardiac:

Palpitations ❑ Yes ❑ No

Chest Pain ❑ Yes ❑ No

Daytime Shortness of Breath❑ Yes ❑ No

Ankle Swelling ❑ Yes ❑ No

Nighttime Shortness of Breath❑ Yes ❑ No

Skin:

Unusual Moles ❑ Yes ❑ No

Rash❑ Yes ❑ No

Dryness❑ Yes ❑ No

Endocrine❑ Yes ❑ No

Heat Intolerance❑ Yes ❑ No

Excessive Thirst❑ Yes ❑ No

Constipation❑ Yes ❑ No

Cold Intolerance❑ Yes ❑ No

Cold Hands/Feet❑ Yes ❑ No

Decreased Libido: ❑ Yes ❑ No

Depressed Mood: ❑ Yes ❑ No

THRIVE
SLEEP & BREATHING

**FAMILY HISTORY**

Do you have a family history of any of the following medical illnesses?
(Check if "yes" to all that apply):

❑ High blood pressure/hypertension
❑ Chronic insomnia
❑ Overweight/obesity
❑ Stroke
❑ Multiple sclerosis
❑ Sleep apnea
❑ Depression
❑ Diabetes
❑ Heart disease
❑ Restless legs syndrome
❑ Snoring
❑ Congestive heart failure
❑ Sleep walking
❑ Anxiety

**ETHNIC BACKGROUND**

This is necessary for diagnostic purposes. We welcome a discussion if you have a concern.

❑ American Indian or Alaskan Native
❑ Asian
❑ Black or African American
❑ Caucasian (European, Middle Eastern, North African Ancestry)
❑ Hispanic or Latino
❑ Native Hawaiian or Pacific Islander
❑ Other: _____

NOTES, Official Use Only: