THRIVE
SLEEP & BREATHING

DEDICATED SLEEP™

COMPREHENSIVE HEALTH QUESTIONNAIRE

The purpose of this questionnaire is to determine the nature of your health problem. It is very important to be as accurate as possible in answering the questions. Your partner may be able to assist you.

Patient Name: _____ **Date:** _____

DOB: _____ Address: _____

Age: _____ _____

Cell Phone: _____ Home Phone: _____

Email: _____ Text OK? Y N

Preference of contact: _____ Emergency Contact: _____

Emergency Contact #: _____ Relation: _____

SSN: _____ Occupation: _____

Sex: Male Female **Marital Status: Single Married/Partnered Widowed Divorced**

Height: _____ Weight:_____

Primary Care Physician: _____ Cardiologist: _____

Pulmonologist: _____ Referring Doctor: _____

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List current medical conditions for which you are being treated.

Diagnosis	Year	Treating Physician

List all hospitalizations and surgeries you have had. (*Please be thorough and include surgeries to remove your adenoids or tonsils, or hospitalizations for head injury, seizures or heart conditions.)*

Diagnosis	Year	Treating Physician

List medications you are currently taking. (*Please include prescription and non-prescription medications of all types, including sleep and non-sleep related. Also indicate if you are on supplemental oxygen.)*

Medication	Reason	Dosage	How often?

Please list any allergies we should be aware of: