Scottsdale Insomnia and Sleep Medicine

SLEEP AND MEDICAL HISTORY

Date_____ Patient Name _____

Date of birth_____ Age_____ Height_____ Weight_____

Current Sleep and Medical Concerns: (please rank by priority)

1._____

2._____

3._____

Current medications: (include dose and frequency)

1._____ 5._____

2._____ 6._____

3._____ 7._____

4._____ 8._____

Allergies to medications: (please include specific reaction)

1._____ 2._____ 3._____

Please list any other physicians involved in your medical care:

1._____ 2._____ 3._____

Past medical history / illnesses / surgeries: (approximate dates)

1._____ 5._____

2._____ 6._____

3._____ 7._____

4._____ 8._____

Have you ever been diagnosed with a psychiatric disorder/mental illness?

Depression Anxiety Panic Disorder Bipolar Disorder Other _____

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