<table>
<thead>
<tr>
<th>SITUATION</th>
<th>CHANCE OF DOZING</th>
</tr>
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<tbody>
<tr>
<td>Sitting and Reading</td>
<td>🛑 0 = none</td>
</tr>
<tr>
<td>Watching TV</td>
<td>🛑 0 = none</td>
</tr>
<tr>
<td>Sitting inactive in a public place (e.g. theatre or meeting)</td>
<td>🛑 0 = none</td>
</tr>
<tr>
<td>As a passenger in a car for an hour without a break</td>
<td>🛑 0 = none</td>
</tr>
<tr>
<td>Lying down to rest in the afternoon when circumstances permit</td>
<td>🛑 0 = none</td>
</tr>
<tr>
<td>Sitting and talking to someone</td>
<td>🛑 0 = none</td>
</tr>
<tr>
<td>Sitting quietly after a lunch without alcohol</td>
<td>🛑 0 = none</td>
</tr>
<tr>
<td>In a car, while stopped for a few minutes in traffic</td>
<td>🛑 0 = none</td>
</tr>
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It is very important for your health that you answer these questions as completely and accurately as you can. If you do not understand something, please ask us for help.

We want you to live a healthier life.
**PAST OR CURRENT MEDICAL PROBLEMS**


**PAST SURGERIES**


**ALLERGIES**

<table>
<thead>
<tr>
<th>Medicine</th>
<th>Reaction</th>
<th>Medicine</th>
<th>Reaction</th>
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**MEDICATIONS**

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<th>Medication</th>
<th>Dose</th>
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**FAMILY HISTORY**

Is there anyone in your family with any of the following conditions:

- Seizures
- Insomnia
- Parkinson’s Disease
- High blood pressure
- Diabetes
- Dementia
- Sleep Apnea
- Excessive Sleepiness
- Coronary Artery Disease
- Narcolepsy

Is there someone in your family with an illness similar to the one for which you are seeing the doctor today?

**PERSONAL HISTORY**

Education Level and Degree(s) ___________________________ Occupation ___________________________

Marital Status _________________________________________ With whom do you live? _________________________

Do you currently smoke? □ No □ Yes Did you use to smoke? □ No □ Yes If yes, when did you quit? _____

Do you drink alcohol? □ No □ Yes If yes, how many drinks per week? ___________________________

Do you currently use recreational drugs? □ No □ Yes

Do you have a history of using recreational drugs? □ No □ Yes

Do you drink coffee, caffeinated sodas, energy drinks or teas? □ No □ Yes If yes, how many cups per day? _____

Do you exercise regularly? □ No □ Yes How many days per week? ___________________________

**REVIEW OF SYSTEMS** Only indicate problems occurring in the last 2 weeks.

**General:**

- □ Fevers or sweats
- □ Weight gain or loss _____ lbs

**Neurologic:**

- □ Passing out
- □ Numbness or tingling
- □ Headache

**Psychiatric:**

- □ Depression
- □ Anxiety
- □ Stressful life event

**Ear, Nose, Throat:**

- □ Sinus congestion
- □ Trouble breathing
- □ Coughing or wheezing

**Musculoskeletal:**

- □ Back pain
- □ Muscle aches or cramps
- □ Joint pain

**Genitourinary:**

- □ Frequent urination

**Cardiovascular:**

- □ Chest discomfort
- □ Rapid or skipped heartbeats

**Endocrine:**

- □ Heat or cold intolerance
- □ Menopausal symptoms
- □ Thyroid problems

**Gastrointestinal:**

- □ Nausea or vomiting
- □ Heartburn

If you are NOT currently having any of the problems listed above, check here: □