

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

**Personal Medical History:**

Have you ever had or been diagnosed with the following (check all that apply):

**Pulmonary:**

- Emphysema/COPD/  
Chronic Bronchitis
- Nasal Congestion
- Pulmonary Embolism
- Lung Cancer

**Sleep:**

- Sleep Apnea
- Narcolepsy
- Insomnia
- Restless Leg Syndrome

**GI:**

- Acid Reflux/GERD

**Cardiac:**

- High Blood Pressure/  
Hypertension
- Heart Attack/  
Coronary Artery Disease
- Congestive Heart Failure
- Atrial Fibrillation
- Pacemaker/  
Defibrillator Placement

**Endocrine:**

- Diabetes
- Thyroid Disease

**Rheumatologic:**

- Arthritis
- Fibromyalgia
- Chronic Pain Syndrome

**Neurological:**

- Epilepsy/Seizures
- Migraine Headache
- Stroke
- Parkinson's Disease
- Alzheimer Disease/Dementia

**Psychological:**

- Depression/Anxiety
- Bipolar Disorder
- Schizophrenia

**ENT:**

- Chronic Sinusitis
- Allergic Rhinitis
- Head and Neck Cancer
- Upper Airway Surgery:  
***If yes, please specify***
- Tonsiectomy
- Adenoidectomy
- Nasal Septum Surgery
- Sinus Surgery
- Uvulopalatopharyngoplasty  
(UPP)
- Other: \_\_\_\_\_

**Other:** \_\_\_\_\_