NEUROLOGY & SLEEP SPECIALISTS
an affiliate of Mountain View Hospital

History Intake Form

Name:_____ **Date**:_____

Pharmacy:_____ **Primary Care Provider**:_____

Past Medical History:(Please check all that apply)

☐ None	☐ Colon Cancer
☐ Anxiety	☐ Lung Cancer
☐ Hepatitis	☐ COPD
☐ Arthritis	☐ Lymphoma
☐ Hypertension (High Blood Pressure)	☐ Coronary Artery Disease
☐ Asthma	☐ Prostate Cancer
☐ HIV/AIDS	☐ Depression
☐ Atrial Fibrillation (Irregular Heartbeat)	☐ Radiation Treatment
☐ Hypercholesterolemia (High Cholesterol)	☐ Diabetes
☐ BPH (Benign Prostate hypertrophy)	☐ Seizure
☐ Hyperthyroidism (High Thyroid)	☐ End stage renal disease
☐ Bone Marrow Transplantation	☐ Stroke
☐ Hypothyroidism (Low thyroid)	☐ GERD (Gastro esophageal reflux disease)
☐ Breast Cancer	☐ Other:_____
☐ Leukemia	

Past Surgical History: (Please circle those that apply) None, Tonsillectomy, Hysterectomy, Gall Bladder, Appendix, Knee, Hip, Back, Shoulder,
Other:_____

_____

Social History

Marital Status: Married/Single/Divorced/Widowed **Children**: _____ **Pets**:_____

Work Status: Full time/ Part time/Retired/ Home Maker/ Disabled

Smoking: Yes/No **Alcohol:** Yes/No/Rarely/Social/Occasionally/Daily **Any Illicit drug use:** Yes/No

Caffeine use:_____ **Diet**:_____ **Exercise**:_____

Family History of disease/illness:

Mother:_____**Father**:_____

Siblings:_____ **Other**:_____

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Name:_____

Please check any items that currently pertain to your health:

☐ Snoring	☐ Trouble staying asleep
☐ Waking feeling unrested	☐ Memory problems
☐ Witnessed apneas/pauses in breathing	☐ Difficulty concentrating
☐ Excessive dry mouth upon awakening	☐ Restless legs
☐ Sore throat in the mornings	☐ Heart palpitations
☐ Sore/stiff neck upon awakening	☐ Waking up gasping for air
☐ Night time urination	☐ Bruxism
☐ Trouble falling asleep	☐ Migraines/headaches

Please answer all questions below:
Time you go to bed:_____
How long it takes to fall asleep (in minutes):_____
How many times you wake up at night:_____
Number of minutes of awake time, each time: _____
Time you wake up in the morning: _____
How long it takes you to get out of bed: _____

Epworth Sleepiness Scale: Likelihood of dozing or falling asleep in the following situations:

Answer using: 0=Never 1=Slight 2=Moderate 3=High chance

Sitting and Reading:_____	Watching Television: _____
Sitting inactive in a public place (e.g., theater, meeting, dinner, event): ____	Passenger in car for over an hour without stopping for a break:_____
Lying down to rest when circumstances permit:____	Sitting talking to someone:_____
Sitting quietly after a meal w/o alcohol: ____	In a car while stopped for a few minutes:_____

_____/24 ESS ***If you score higher than 10 from above, then fill out the following:**

Swiss Narcolepsy Scale: Answer using: **1**=Never **2**=Rarely **3**=Sometimes **4**=Often **5**=Almost always

How often are you unable to fall asleep?_____
How often do you feel bad or not well rested in the a.m.?_____
How often do you nap during the day?_____
How often have you experienced weak knees or buckling of the knees during emotions such as laughing, happiness, or anger?_____
How often have you experienced sagging of the jaw during emotions such as laughing, happiness, or anger?_____

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Name:_____

Please list all medications that you are currently taking, including nonprescription medications and herbal supplements. (or supply an current list)

Medication Name:	Amount Taken:	Frequency:

Allergies:_____