**Current Medication List**

**Patient Name:** **Date:**

**Medications (Circle ones taken day of your sleep test):**

1.

2.

3.

4.

5.

6.

7.

8.

9.

10.

**Allergies:**

1.

2.

3.

**DO YOU HAVE A PACEMAKER?** YES\_\_\_\_ NO\_\_\_\_

**How did you hear about us?**

□ My physician □ Friend □ Radio □ Yellow Pages □ Online Ad □ Online Search □ Educational Conference □ TV □ Newspaper, If so which one? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ □ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

COMMENTS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Office Use ONLY**

APPOINTMENT DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Age:** \_\_\_\_\_\_\_ years old

**Height:** \_\_\_\_\_\_\_\_ feet \_\_\_\_\_\_\_\_ inches

**Weight:**  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ lbs.

**Blood Pressure:**  \_\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_\_\_ Right Arm Left Arm

**Reason for Appointment:**

**Sleep Apnea**

**Insomnia**

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