The Snoring Center

Name: ____________________ Age: ________ Birthdate: ____________

How did you hear about us? ______________________________

Name and address of your primary care provider (your regular family doctor):

____

______________________________ Phone: ______________

Reason for today's visit?

____

Have you ever had a sleep study? ____ No ____ Yes: Date: __________ Where: ______________

Results: ____

PAST HISTORY

Please list any prior major illnesses and/or injuries:

____

____

Please list any surgeries or hospitalizations:	Year	Complications

Please list current medication(s) including aspirin:

Drug	Dose	Frequency	Drug	Dose	Frequency

Please list any allergies or reactions to medications or other materials:

Do you smoke, or have you smoked previously?
____ Yes, I quit smoking _______ (years/months) ago.
____ Yes, I've smoked ____ packs of cigaretes per day for ____ years.
____ Yes, I smoke cigars or a pipe.
____ No, I have never smoked.
Do you drink alcohol? ____ Yes: ____Daily ____One or more times a week ____Occasionally
____ No
What is your occupation? (or if retired, prior occupation) ______________________________

Craig Schwimmer, MD, MPH • Medical Director
6901 Snider Plaza, Suite 225, Dallas, TX 75205 • Phone 214.369.2345 Fax 214.369.7464
1014 E. Wheatland Rd., Duncanville, TX 75116 • Phone 972.298.2345 Fax 972.298.4161
www.snoringcenter.com