CARLOS R. SANTOS MD., PA
SLEEP DIAGNOSTIC CENTER

SLEEP HISTORY

NAME: _____D.O.B _____ DATE: _____
REFERAL PHYSICIAN: _____
AGE: _____ WEIGHT: _____ HEIGHT: _____

How many hours do you sleep on a typical night? _____ Hours

How long does it take for you t sleep on a typical night? _____ Minutes

Check all that are applicable to you:

( ) Very tired/Sleepy during the day
( ) Wake up sweating at night
( ) Wake up with palpitations
( ) Very loud snoring during sleep
( ) Wake up with shortness of breath
( ) Frequent arousals at night

Medical History:

Have you ever been told you have sleep apneas ( ) **Yes** ( ) **No**

Have you ever had a sleep study done before? ( ) **Yes** ( ) **No**
If yes, list when y where:

_____
_____

Do you have cardiac (heart) problems? ( ) **Yes** ( ) **No**
If yes, list on space below:

_____
_____

Do you have any other MEDICAL problems? ( ) **Yes** ( ) **No**
If yes, list on space below:

_____
_____

Do you take sleeping medications? ( ) **Yes** ( ) **No**
If yes, list on space below:

_____
_____

List all current medications:

_____
_____

List all previous surgeries:

_____
_____

3164 S UNIVERSITY DR. MIRAMAR, FL, 33025
PHONE (954) 849-0621
FAX (305) 384-7279