MEDICAL QUESTIONNAIRE

Please complete this questionnaire prior to your first session. You may do so in the waiting room before the session but are encouraged to complete the questionnaire prior to your arrival in the office. You may print this questionnaire by clicking here.

Name: _____ Today's date: _____

Date of birth: _____ Place of birth: _____

Marital status: _____ Occupation: _____

Years of education: _____ Medication allergies: _____

PCP's name: _____ _____

PCP's location: _____ Current medications (including prescription, over-the-counter, and alternative): _____

Do you have a history of...

...epilepsy/seizures?	*yes*	*no*
...sleep apnea?	*yes*	*no*
...snoring?	*yes*	*no*
...daytime fatigue?	*yes*	*no*
...diabetes?	*yes*	*no*
...high blood pressure?	*yes*	*no*
...heart problems?	*yes*	*no*

Other medical illnesses: _____ Surgical history: _____

_____ _____

_____ _____

_____ _____

Family History	*(if living, note current age and any health problems)* Age	Health problems	*(if deceased, indicate age and cause of death)* Age	Cause of death
Mother	_____	_____	_____	_____
Father	_____	_____	_____	_____
Brothers/ Sisters	_____	_____	_____	_____
	_____	_____	_____	_____
	_____	_____	_____	_____
	_____	_____	_____	_____
	_____	_____	_____	_____
Children	_____	_____	_____	_____
	_____	_____	_____	_____
	_____	_____	_____	_____
	_____	_____	_____	_____
	_____	_____	_____	_____