# Bristol Primary Care LLC

## Sleep intake form (page 1 of 2)

Today's date: _____  Date of birth: _____

First name: _____  Last name: _____

### Social history (please circle yes or no):

Do you drink caffeinated beverages?............. Yes  No     How much in 24 hours? _____

Do you drink beer or wine?........................... Yes  No     How much in 24 hours? _____

Do you drink liquor? ..................................... Yes  No     How much in 24 hours? _____

Do you use any tobacco products? ................. Yes  No     How much in 24 hours? _____

### Current health concerns (circle all that apply):

| | | |
|---|---|---|
| ADD/ADHD | Heart attack | Morning headaches |
| Anxiety | Heart failure | Seizures |
| Depression | Heartburn | Sleep problems |
| Diabetes | High blood pressure | Stroke |
| Fibromyalgia | Irregular heartbeat | Other: _____ |

### Surgical history (circle all that apply):

| | | |
|---|---|---|
| Adenoids removed | Nasal surgery | Tonsils removed |
| Heart surgery | Palate surgery | Weight loss surgery |

### Family history (circle all that apply and list family relationship):

| | | |
|---|---|---|
| ADD/ADHD | Heart surgery | Seizures |
| Adenoids removed | Heartburn | Surgery on roof of the mouth |
| Anxiety | High blood pressure | Stroke |
| Depression | Irregular heartbeat | Tonsils removed |
| Diabetes | Morning headaches | Weight loss surgery |
| Fibromyalgia | Nasal surgery | Other: _____ |
| Heart attack | Problems falling or staying asleep | _____ |
| Heart failure | | |

**Check all symptoms that apply:**

___Frequent headaches

___Fainting or passing out

___Sudden loss of vision or strength

___Unable to walk

___Hearing loss or ringing in ear(s)

___Hoarseness for more than 2–4 weeks

___Coughing up blood

___Shortness of breath or wheezing

___Swelling in the feet or ankles

___Chest pain, tightness or pressure

___Irregular or sudden fast heartbeat

___Difficulty swallowing or food "sticking" in throat

___Frequent heartburn or indigestion

___Stomach pain

___Frequent constipation

___Frequent diarrhea

___Rectal bleeding/black stools

___Difficulty urinating or leaking urine

___Blood in urine

___Urinating more than twice per night

___Pain in joints or bones

___Unusual bruising or bleeding

___Change in a wart, mole or skin growth

___Weight loss of more than 5–10 lbs.

___Memory or concentration problems