HISTORY & PHYSICAL

NAME _____ **DATE** _____

HABITS

Do you currently smoke? Yes ☐ No ☐ Type of tobacco used: Cigarettes ☐ Pipe ☐ Cigars ☐

Have you ever smoked? Yes ☐ No ☐ What year did you quit? _____

How many did you smoke per day? _____

Do you drink alcohol? Yes ☐ No ☐

How many drinks do you have? Daily: _____ Weekly: _____ Yearly: _____

Drug abuse: Past Present Type _____

Exercise Routine: _____

Coffee/Cups Daily: _____ Other Caffeine: _____

SLEEP

Difficulty falling asleep? Yes ☐ No ☐
Early morning awakening? Yes ☐ No ☐
Continuity of disturbance? Yes ☐ No ☐
Snoring? Yes ☐ No ☐
Daytime drowsiness? Yes ☐ No ☐

WOMEN ONLY

Pregnant? Yes ☐ No ☐
Planning pregnancy? Yes ☐ No ☐
Date of last period:
Date of last pelvic exam:

_____

Patient's Signature *Date*