Dr. Alex A. Clerk's Office
O'Connor Health Center 1
455 O'Connor Drive,
Suite 110,
San Jose, CA. 95128

Main: 408.295.4532
Fax: 408.295.4738
Email: info@sleepmedicineservice.com
Web: sleepmedicineservice.com

Sleep Evaluation

Sleep Disorders Clinic

Name: Date:

Age: Height: Weight: Sex: ☐Male ☐Female

1. My Chief Compliant is?

2. List Past Illnesses: ☐None

3. List Past Surgeries: ☐None

4. Current Medications: ☐None

5. Medications Allergies: ☐None

Dr. Alex A. Clerk's Office
O'Connor Health Center 1
455 O'Connor Drive,
Suite 110,
San Jose, CA. 95128

Main: 408.295.4532
Fax: 408.295.4738
Email: info@sleepmedicineservice.com
Web: sleepmedicineservice.com

Sleep Evaluation

6. Social History

Do you have Children? ☐No ☐Yes - If yes how many? _____

Do you exercise? ☐No ☐Yes - If yes please describe type: _____

Describe your Diet: ☐Average ☐Vegetarian ☐Poor

Do you Smoke? ☐No ☐Yes - If yes how many pack a day: _____

Do you use Alcohol? ☐No ☐Yes

Do you use any Recreational Drugs? ☐No ☐Yes

7. Family History

(List any medical condition(s) the following family member have or may have had)

Mother's Name:_____

Date of Birth:_____

Medical Conditions:

_____

_____

Father's Name:_____

Date of Birth:_____

Medical Conditions:

_____

_____

Sibling's Name:_____

Date of Birth:_____

Medical Conditions:

_____

_____

Other Family Member's Name:_____

Date of Birth:_____

Medical Conditions:

_____

_____