Sleep Study Intake Form

for Cardiovascular Patients

Patient Information

Full Name

Date of Birth

Age

Gender

Email

Phone Number

Address

Referring Cardiologist

Name

Contact Info

Medical History

Cardiovascular Conditions

Other Medical Conditions

Current Medications

Allergies

Sleep History

Main Sleep Concerns

Duration of Sleep Problems (months/years)

Do you snore?

Daytime Sleepiness

Previous Diagnosis of Sleep Apnea?

Lifestyle & Habits

Smoking Status

Alcohol Use

Exercise Habits

Additional Comments