Pertinent Medical History

Name:_____ **Date:**_____

Please circle the correct response

Have you ever suffered from a heart attack or stroke? **YES NO**

Do you have Congestive Heart Failure? **YES NO**

Have you been diagnosed with an irregular heartbeat? **YES NO**
If so, what type? _____

Do you have a pacemaker? **YES NO**

Do you suffer from hypertension? **YES NO**

Do you suffer from COPD? **YES NO**

Have you ever been, or are you currently on supplemental oxygen? **YES NO**
If so, how many liters per minute?
Night? _____ Lpm Day? _____ Lpm 24 hrs?____ Lpm

Are you chronically congested? **YES NO**

Do you suffer from claustrophobia? **YES NO**

Do you have a communicable illness (such as HIV, Hepatitis, etc.)? **YES NO**

Are you on medication for chronic pain? **YES NO**

Do you have allergies to latex or any adhesives? **YES NO**

Have you undergone a surgical procedure for sleep apnea? **YES NO**

Do you suffer from a general anxiety disorder? **YES NO**

Comments:_____

Thank you, COSDC staff.