

FOLLOW UP VISIT

Pharmacy & Phone	Name:DOB:			DOB:	Changes to address/phone/insurance? □ No □ Yes				
Pharmacy & Phone									
Since your last visit have you:									
Seen a physician/health care provider had any changes in your medical history/ medications been hospitalized or undergone surgery had any changes in your housing, employment, or education had any changes in your housing, employment, or education had any changes to your use of caffeine, tobacco, or alcohol No Yes - please describe: Seen a physician/health care provider Significant headaches Significant	'narm	асу а	& Phone	CPAP/BIPA	P/Oxygen Supply Compan	У			
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been hospitalized or undergone surgery had any births, deaths or major illnesses in blood relatives had any changes in your housing, employment, or education had any changes to your use of caffeine, tobacco, or alcohol No									
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had any changes in your housing, employment, or education had any changes to your use of caffeine, tobacco, or alcohol No Yes - please describe:	•	beer	n hospitalized or undergone surgery						
No									
2. Have you experienced any of the items below recently? N Y									
2. Have you experienced any of the items below recently? N Y	•	had	any changes to your use of caffeine, tobacco,	or alcohol					
2. Have you experienced any of the items below recently? N Y		No	□ Vos Inlanca describe:						
Bed Time:	Ц	INO	□ Yes - please describe:						
Bed Time:									
Bed Time:									
Bed Time:									
# of Awakenings Hours of Sleep: Amount of time to fall asleep minutes My sleep is better worse about the same Cough, shortness of breath, wheezing, asthma									
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