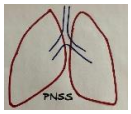

Pulmonary N Sleep Specialists PC

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SLEEP & MEDICAL HISTORY

Name _____ Date of Birth _____

Reason for today's visit _____ Date of Visit _____

Family Physician _____ Referring Physician _____

Name of other physician to send reports to _____

SLEEP HISTORY

	YES	NO
1. Do you have any trouble falling asleep?		
2. Do you have trouble staying asleep?		
3. Do you have trouble getting up after sleeping?		
4. Do you snore? Light/loud?		
5. Do you fall asleep while watching TV, reading, or driving?		
6. Do you take naps? Occasionally/regularly/never? Do you dream during naps?		
7. Do you wake up in the morning refreshed?		
8. Do you wake up in the morning with headaches? Dry mouth?		
9. Have you been in an automobile accident because of sleepiness while driving?		
10. Does your sleepiness interfere with your ability to function normally?		
11. Is your bed partner disturbed by your sleep problems?		
12. Do you work variable or rotating shifts?		
13. Do you stop breathing when sleeping?		
14. Do you wake up from sleeping snorting or choking?		
15. Do you walk in your sleep? Grind your teeth?		
16. Do you experience vivid dream or feel paralyzed when going to sleep or awakening?		
17. Have you felt weakness in your knees when you laugh?		
18. Do you experience creeping, crawling, or an aching sensation on your legs when you go to sleep?		
19. Do you watch a clock, TV, or have racing thoughts, or worry about the next day when trying to fall asleep?		
20. Do you exercise before going to sleep?		
21. Do you wake up too early?		
22. Do you use over the counter or prescription sleeping or waking pills?		

Name _____ Date of Birth _____

SLEEP SCHEDULE:

Usual bedtime:_____ Wake time:_____

How many hours do you sleep each night?_____

About how long does it take for you to fall asleep?_____

About how many times do you wake up each night?_____

When you awaken during the night, how long are you awake?_____

Do you easily go back to sleep after waking in the middle of sleep?_____

What are your work hours?_____

SLEEP THERAPEUTICS:

Do you use a CPAP or BiPAP?	YES	NO If no move onto next section past medical history
Is you use a CPAP or BiPAP, how many hours each night? How many days/ week?		
Do you have issues with dryness of nose, nose bleeds, air leaks with masks?	YES	NO
What DME company do you get your machine/ equipment from?		
What kind of mask do you use?		
What are your settings?		
Do you currently take any sleeping pills? If so which one(s) and how often?		
Do you use melatonin or alcohol to help you to go to sleep?	YES	NO
Do you take any medication or caffeinated beverages to help you to stay awake?	YES	NO

PAST MEDICAL HISTORY

HAVE YOU EVER HAD:	**YES**	**NO**	**YEAR**	**HAVE YOU EVER HAD:**	**YES**	**NO**	**YEAR**
Sleep apnea				Tonsillectomy/ sinus surgery			
Insomnia				Surgery for sleep apnea			
Sleep walking				Other sleep disorders			
Coughing up blood				Sinus/ nasal problems			
COPD/ asthma/ emphysema				Pneumonia/ Tuberculosis			
High blood pressure				Congestive heart failure			
Heart attack/ catheterization				Heart surgery/ angioplasty			
Goiter/ thyroid problem				Stroke/ seizure			
Diabetes				Nervous disorder			
Anxiety, claustrophobia				Nose surgery/ nasal polyps			
Other surgeries				Wear dentures/ partials			

Name _____ Date of Birth _____

What is your weight now_____ 6 months ago_____ 2 months ago_____

Any other illness or diseases:_____

Have you ever had a serious injury or accident?_____

Last flu vaccine (mm/yy) ___/___ Last pneumonia vaccine (mm/yy) ___/___

EPWORTH SLEEPINESS SCALE

Complete the scale by: "How likely are you to doze off or fall asleep in these situations?"

0= would never doze off
1= slight chance of dozing
2= moderate chance of dozing
3= high chance of dozing

SITUATION	CHANCE OF DOZING
Sitting and reading	
Watching TV	
Sitting inactive in a public area	
As a passenger in a car for an hour without a break	
Lying down in the afternoon	
Sitting and talking to someone	
Sitting quietly after lunch without alcohol	
In a car, while stopped for a few minutes in traffic	
TOTAL:	

ALLERGIES:

Do you have any allergies to medication, food, or insect stings? YES NO
If so, please list the allergies and reactions below:

Medicine/ Allergen	Reaction

CURRENT OR PAST USE OF ANY OF THESE MEDICATIONS? DEVICES:

	YES	NO	DETAILS
Oxygen			
Nebulizers			
Inhalers			

Name _____ Date of Birth _____

CURRENT MEDICATIONS (PLEASE LIST YOUR INHALERS/NEBULIZERS):

MEDICATION NAME	DOSE	HOW OFTEN

REVIEW OF SYSTEMS :

Are you currently having any of the following:	YES	NO
1. Weight change of more than 5 pounds in the last 6 months?		
2. Recent unexplained fever, chills or night sweats?		
3. Do you feel fatigued or tired?		
4. Do you have dizziness, lightheadedness, vertigo or fainting spells?		
5. Do you have headaches?		
6. Do you have any vision problems other than prescription glasses or contact lenses?		
7. Do you have any problems with hearing: hearing loss, ringing, earache, itching?		
8. Do you have any nosebleeds or difficulty breathing through your nose?		
9. Do you get heart palpitations or fluttering (racing of heart or skip beats)?		
10. Do you have any heart troubles including heart murmurs or chest pains?		
11. Do you have any trouble swallowing?		
12. Do you get heartburn or sour taste in your mouth?		
13. Has there been any recent change in your appetite?		
14. Do you have cough, sinus drainage, or wheezing?		
15. Do you have nausea, vomiting, diarrhea, constipation, or pain in your stomach?		
16. Do you have intolerance to hot or cold surroundings?		
17. Do you have excessive thirst or excessive urination?		
18. Do your joints swell, hurt or feel stiff?		
19. Do you tremble or shake abnormally?		
20. Do you have phlegm, shortness of breath, or do you cough up blood?		
21. Do you have swelling in your feet?		
22. Do you have any shortness of breath or chest pain?		
23. Do you sleep propped up in bed or in a recliner? Why?		
24. Do you suffer from recurrent sore throats or bronchitis?		
25. Do you have bleeding tendency, anemia, easy bruising?		
26. Do you have any urine disturbance?		

Name _____ Date of Birth _____

Females: Are you currently pregnant or is there a chance you could be pregnant? NO YES

FAMILY HISTORY (blood relatives only)

Relative		Present Age or Age at Death	Present Health or Cause of Death
Father	Living? Yes No		
Mother	Living? Yes No		
Brothers	Number Living? Number deceased?		
Sisters	Number living: Number deceased?		
Children	Number living: Number deceased?		

HAVE ANY OF YOUR BLOOD RELATIVES HAD (IF YES, INDICATE RELATIONSHIP)

	YES	NO	RELATIONSHIP		YES	NO	RELATIONSHIP
Asthma				Emphysema			
Lung Cancer				Diabetes			
High blood pressure				Heart Disease			
Tuberculosis				Arthritis			
Lupus				Cancer			
Stroke				Sleep Apnea			
Seizures				Narcolepsy			

SOCIAL HISTORY

Do you now or have you ever smoked cigarettes, cigar or pipe? NO YES

Now? NO YES If yes, how many packs per day? _____ For how long? _____

In the past? NO YES If yes, when did you quit? _____

Does your spouse or anyone living in your house smoke? NO YES

Do you drink alcohol on a regular basis? NO YES

If yes, how much and how often? _____

Do you drink caffeinated beverages on a regular basis? NO YES

If yes, what kind and how often? _____

Do you use any illicit drugs? NO YES

Do you exercise on a regular basis? NO YES

_____

Reviewing Provider's Signature