Name: _____
DOB: _____

Questions are sleep and pulmonary related. Please complete ALL questions to the best of your ability as we are aware you may be here for only sleep or only pulmonary issues.

What is the primary reason for this examination?

Please describe your problem in your own words. If possible, specify how long you have had trouble and what has been done about it so far. How has it affected the quality of your life?

Past Medical History

1. How would you rate your overall health?

   Excellent___ Good___ Fair___ Poor___

2. Have you ever been diagnosed or treated for any of the following? If yes, When?

   _____Hypertension
   _____Cardiac Arrhythmia (heart irregularities
   _____Coronary Arteries
   _____Angina (heart pain)
   _____Myocardial Infarction (heart attack)
   _____Congestive Heart Failure
   _____Pulmonary Hypertension
   _____Polycythemia (excessive red blood clots)
   _____Diabetes
   _____Stroke
   _____Edema
   _____High Cholesterol
   _____Hiatal Hernia
   _____Gastric Reflux
   _____Hypothyroidism (low)
   _____Hay fever or allergic Rhinitis
   _____Vocal Cord Disease
   _____Asthma
   _____Bronchitis
   _____Emphysema
   _____Other lung disease
   _____Depression
   _____Other Neurological Disorder

3. List any other medical illnesses you have:

4. List any surgeries or hospitalizations you have had (include minor operations such as tonsillectomy and adenoidectomy):

Operation or Hospitalization	Date

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_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

5. Have you had any serious accidents? (explain)
6. Have you ever had a blood transfusion? (explain)
7. Have you ever had any exposure to dangerous chemicals? (explain)

Personal Habits & Social History

1. Cigarette Smoking:

   Have you ever smoke regularly? No___ Yes___ (if not go to #2)

   How many years altogether have you smoked? _____

   How many packs a day did/do you smoke? _____

   Do you presently smoke? No___ Yes___

   When did you quit? _____

2. Alcohol Use:

   Do you currently drink alcohol? No___ Yes___ (if not go to #3)

   What kind of alcohol do you drink? _____

   How much? _____

   How often? _____

3. Caffeine Use:

   Do you drink caffeinated beverages? No___ Yes___ (if not go to #4)

   Coffee____ Tea____ Caffeinated Soda____

   What is your consumption in a 24 hour period?

4. Do you take any medications to stay awake? _____
5. Do you use “recreational” drugs? No___ Yes___ Describe:_____
6. Do you follow a special diet? No___ Yes___

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Describe: _____

7. Do you exercise? No___ Yes___ Describe:_____
8. Describe your current work situation (job title, satisfactory, etc.)?
9. Describe current relationship status (spouse, children, etc.)?

Family History

Please circle illnesses which have occurred in your BLOOD relatives:

Hypertension	Stroke	Allergies	Asthma Diabetes
Cardiac Disease	Sleep Apnea	Narcolepsy	Sleep Walking

Cancer (describe) _____

Other: _____

	Living	Age (or age of death)	Health problems or cause of death
Father	Y N	_____	_____
Mother	Y N	_____	_____

How many Sisters: _____ How many Brothers: _____ How many Children: _____

Medications

List all medications, including over the counter medications that you take (even if it is not on a regular basis).

Medication	Dosage	Frequency
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Drug Allergies: _____

Review of symptoms

1. Have you gained/lost weight in the last 12 months? No___ Yes___ How much? _____
2. Do you have a problem breathing through your nose? No___ Yes___

Please circle one: Some Moderate Severe

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3. If you are male, have you had a problem with impotency? No___ Yes___
4. Do you have any difficulties with physical exertion such as unusual shortness of breath, difficulty breathing, or discomfort? No___ Yes___ Describe:_____
5. Do you have chronic cough? No___ Yes___ Describe:_____
6. Do you have excessive phlegm or sputum? No___ Yes___ Describe:_____
7. Do you have episodes of wheezing or chest tightness? No___ Yes___ Describe:_____
8. Have you had swelling of your ankles or feet? No___ Yes___ When? _____
9. Do you have difficulty with swallowing food, indigestion, heartburn, or regurgitation of acid back into your throat or mouth? No___ Yes___ Describe:_____
10. Have you had any changes in your usual bowel habits recently (constipation, change in color or shape, etc.)? No___ Yes___ Describe:_____
11. Do you have difficulty passing urine such as burning, blood, or poor stream?
    No ___Yes___Describe:_____
12. Have you experienced any neurological problems such as persistent loss of sensation, loss of muscle strength, poor circulation, balance difficulty, or memory loss?

    No___ Yes___ Describe: _____
13. Do you have persistent arthritis, joint pain, or musculoskeletal discomfort?

    No___ Yes___ Describe: _____
14. Do you have excessive dry skin: No___ Yes___ Describe:_____
15. Do you have a strong preference for cool or warm environment? No___ Yes___

    Describe: _____
16. Please describe any other persistent symptoms that seem important to you:
    _____
    _____

Epworth Sleepiness Scale

Sleep specialist evaluation recommended if score of 10 or greater.

0 = would never doze or sleep

1 = Slight chance of dozing or sleeping

2 = Moderate chance of dozing or sleeping

3 = High chance of dozing or sleeping

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Situation	**Chance of Dozing or Sleeping**
Sitting and reading	_____
Watching TV	_____
Sitting inactive in a public place	_____
Being a passenger in a motor vehicle for an hour or more	_____
Lying down in the afternoon	_____
Sitting and talking with someone	_____
Sitting quietly after lunch (no alcohol)	_____
Stopped for a few minutes in traffic while driving	_____
Score:	_____

Review of Sleep Disorder Symptoms

	Never	Rarely	Sometimes	Frequently	Constantly
Do you snore	_____	_____	_____	_____	_____
Have you been told you stop breathing	_____	_____	_____	_____	_____
Notice your heart ponding/beating irregular	_____	_____	_____	_____	_____
Have trouble at work/school due to sleepiness	_____	_____	_____	_____	_____
Feel afraid of falling asleep	_____	_____	_____	_____	_____
Fall asleep while driving	_____	_____	_____	_____	_____
Have nightmares	_____	_____	_____	_____	_____
Remember your dreams	_____	_____	_____	_____	_____
Fall asleep during physical activity	_____	_____	_____	_____	_____
Fall asleep when laughing or crying	_____	_____	_____	_____	_____
Difficulty with legs jerking or hurting at night	_____	_____	_____	_____	_____

General Sleep Habits

1. How many hours sleep do you get per night? _____
2. Do you usually: (check all that apply)
   - ( ) sleep with someone else in your bed
   - ( ) sleep with someone else in you room
   - ( ) provide assistance to someone during the night (child, invalid, partner, animal)
   - ( ) sleep in a quite comfortable bed. If not, explain _____

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( ) use one pillow. If not, explain _____

3. What time do you usually go to bed? _____Weekdays _____ Weekends
4. How long does it take you to fall asleep? _____
5. As you fall asleep or awaken do you have hallucinations or nightmares? No___ Yes___

   Describe: _____
6. Do your legs feel restless or uncomfortable before falling asleep or do you kick your legs during sleep? No___ Yes___ Describe:_____
7. Do you snore, gasp for air, or turn blue in your sleep? No___ Yes___
8. Do you awaken paralyzed or unable to move your arms and legs? No___ Yes___

   If yes, Describe: _____
9. How many times do you typically wake up at night? _____
10. If you wake up, on average, how long do you stay awake? _____
11. If you wake during the night, which parts of your sleep period is it? (check all that apply)

    ( ) soon after falling asleep

    ( ) middle of the night

    ( ) morning
12. What do you usually do when you awaken during the night? _____
13. What time do you usually awaken in the mornings? _____Weekdays _____ Weekends
14. Do you ever awaken with a headache? No___ Yes___
15. How long do you stay in bed after you wake up in the mornings? _____
16. Upon awakening in the morning do you feel rested? _____
17. Is your sleep often disturbed by: (check all that apply)

    ( ) heat ( ) bed partner ( ) other: _____

    ( ) cold ( ) not being in your own bed

    ( ) noise ( ) any physical pain you have

    ( ) light ( ) any shortness of breath
18. Are your sleep habits on weekends different for the rest of the week? No___ Yes___

    Describe: _____
19. Do your sleep problems disturb your sex life? _____
20. Is your present social life satisfactory? No___ Yes___
21. Does your sleep problems require you to cut back on social activities? No___ Yes___

    If so, how? _____

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