



**Pulmonary & Critical Care
Medicine Associates**

Expertise, Compassion, Results

Address: 50 N 12th Street, Lemoyne, PA 17043

Phone: 717-234-2561

PATIENT INFORMATION

Name: _____ Birth Date: _____

Address: _____ City: _____ State: _____ Zip: _____

Gender: Male Female (circle one) Marital Status: Married Divorced Widowed Single (circle one)

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Referring Physician: _____ Family Physician: _____

Emergency Contact: _____ Relationship: _____

Emergency Contact Phone: _____

NEW SLEEP PATIENT QUESTIONNAIRE

What brings you to our office today? _____

How long have you had this problem? _____

Have you seen a sleep doctor in the past? _____ If yes, who? _____ when? _____

PAST MEDICAL HISTORY

- | | | | |
|--|---|---|-------------------------------------|
| <input type="checkbox"/> Sleep apnea | <input type="checkbox"/> Insomnia | <input type="checkbox"/> Restless leg syndrome | <input type="checkbox"/> Narcolepsy |
| <input type="checkbox"/> COPD/Emphysema | <input type="checkbox"/> Diabetes | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Coronary artery disease | <input type="checkbox"/> Hypothyroidism | <input type="checkbox"/> Congestive heart failure | <input type="checkbox"/> Others |

Do you have any of the following in your home? (Check if applicable):

- Oxygen Nebulizer machine CPAP/BiPAP

If yes, who is your medical supplier (DME)? _____

PAST SURGICAL HISTORY

- | | | |
|---|--|--|
| <input type="checkbox"/> CABG (bypass surgery) | <input type="checkbox"/> Heart valve replacement | <input type="checkbox"/> Appendectomy |
| <input type="checkbox"/> Cholecystectomy (gall bladder removal) | <input type="checkbox"/> Nasal surgery | <input type="checkbox"/> Other surgeries |

ALLERGIES

- Medications None Yes _____

Patient Name: _____ Date of Birth: _____

FAMILY HISTORY

Check if applicable, and list which family member has the condition:

Condition	Yes	Who	Condition	Yes	Who
Sleep apnea	_____	_____	High blood pressure	_____	_____
Narcolepsy	_____	_____	Heart disease	_____	_____

SOCIAL HISTORY

Do you smoke? _____ Have you ever smoked? _____ If yes, how many packs per day? _____

How many years have you been smoking? _____ If no longer smoking, when did you quit? _____

How many years did you smoke before you quit? _____ Does anyone in your house smoke? _____

Do you drink alcohol? _____ If yes, how often? _____

Do you use street drugs? _____ What is/was your occupation? _____

SLEEP HISTORY QUESTIONNAIRE

- | | |
|---|---|
| <ul style="list-style-type: none"><input type="checkbox"/> I have been told that I snore.<input type="checkbox"/> I have been told that I stop breathing when I sleep<input type="checkbox"/> I have high blood pressure.<input type="checkbox"/> My friends and family stay that I'm grumpy and irritable.<input type="checkbox"/> I have fallen asleep while driving.<input type="checkbox"/> I have noticed my heart pounding or beating irregularly during the night.<input type="checkbox"/> I get morning headaches.<input type="checkbox"/> I suddenly wake gasping for breath.<input type="checkbox"/> I am overweight.<input type="checkbox"/> I seem to be losing my sex drive.<input type="checkbox"/> I often feel difficulty falling asleep.<input type="checkbox"/> I frequently wake with a dry mouth.<input type="checkbox"/> I have difficulty falling asleep.<input type="checkbox"/> Thoughts race through my mind and prevent me from sleeping.<input type="checkbox"/> I anticipate a problem with sleep several times a week.<input type="checkbox"/> I wake up and cannot go back to sleep.<input type="checkbox"/> I worry about things and have trouble relaxing.<input type="checkbox"/> I wake up earlier in the morning than I would like to.<input type="checkbox"/> I like awake for half an hour or more before I fall asleep. | <ul style="list-style-type: none"><input type="checkbox"/> When I am angry or surprised, I feel like my muscles go limp.<input type="checkbox"/> I often feel like I am in a daze.<input type="checkbox"/> I have experienced vivid dreamlike scenes.<input type="checkbox"/> I have fallen asleep in social settings such as the movies or at a party.<input type="checkbox"/> I have trouble at work because of sleepiness.<input type="checkbox"/> I have dreams soon after falling asleep or during naps.<input type="checkbox"/> I have "sleep attacks" during the day no matter how hard I try to stay awake.<input type="checkbox"/> I have had episodes of feeling paralyzed during my sleep or on awakening.<input type="checkbox"/> Other than when exercising, I still experience muscle tension in my legs.<input type="checkbox"/> I have noticed (or others have commented) that parts of my body jerk during sleep.<input type="checkbox"/> I have been told I kick at night.<input type="checkbox"/> When trying to go to sleep, I experience an aching or crawling sensation in my legs.<input type="checkbox"/> I experience leg pain and cramps at night.<input type="checkbox"/> Sometimes I can't keep my legs still at night. I just have to move them to feel comfortable.<input type="checkbox"/> Even though I slept during the night, I feel sleepy during the day. |
|---|---|

Patient Name: _____ Date of Birth: _____

REVIEW OF SYSTEMS

- | | | | | | |
|-------------------------|--|---|---|--|--|
| General | <input type="checkbox"/> Weight loss | <input type="checkbox"/> Weight gain | <input type="checkbox"/> Fever | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Night sweats |
| Sleep | <input type="checkbox"/> Excessive sleepiness | <input type="checkbox"/> Snoring | <input type="checkbox"/> Non-refreshing sleep | <input type="checkbox"/> Sleep walking | <input type="checkbox"/> Insomnia |
| ENT | <input type="checkbox"/> Post nasal drip | <input type="checkbox"/> Sinus congestion | <input type="checkbox"/> Nasal polyps | <input type="checkbox"/> Hoarseness | <input type="checkbox"/> Ulcers in mouth |
| Respiratory | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Chronic cough | <input type="checkbox"/> Coughing up blood | <input type="checkbox"/> Wheezing | <input type="checkbox"/> Pleurisy |
| Cardiovascular | <input type="checkbox"/> Chest pain | <input type="checkbox"/> Leg swelling | <input type="checkbox"/> Palpitation | <input type="checkbox"/> Passing out | <input type="checkbox"/> Irregular heartbeat |
| Gastrointestinal | <input type="checkbox"/> Swallowing difficulty | <input type="checkbox"/> Acid reflux | <input type="checkbox"/> Abdominal pain | <input type="checkbox"/> Vomiting | <input type="checkbox"/> Blood in stool |
| Genitourinary | <input type="checkbox"/> Frequent urination | <input type="checkbox"/> Incontinence | <input type="checkbox"/> Hesitancy | <input type="checkbox"/> Urgency | <input type="checkbox"/> Blood in urine |
| Musculoskeletal | <input type="checkbox"/> Joint stiffness | <input type="checkbox"/> Joint pain | <input type="checkbox"/> Back pain | <input type="checkbox"/> Muscle weakness | <input type="checkbox"/> Muscle pain |
| Hematology | <input type="checkbox"/> Lymph gland swelling | <input type="checkbox"/> Blood clots | <input type="checkbox"/> Easy bruising | <input type="checkbox"/> Cancer | <input type="checkbox"/> Anemia |
| Nervous system | <input type="checkbox"/> Weakness | <input type="checkbox"/> Tremors | <input type="checkbox"/> Headache | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Restless legs |
| Endocrinology | <input type="checkbox"/> Loss of appetite | <input type="checkbox"/> Cold intolerance | <input type="checkbox"/> Heat intolerance | <input type="checkbox"/> Goiter | <input type="checkbox"/> Excessive thirst |
| Skin | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Eczema | <input type="checkbox"/> Itching | <input type="checkbox"/> Hair loss | <input type="checkbox"/> Rash |

MEDICATIONS

Please write or provide a list of ALL medications you are currently taking, including prescription, over-the-counter, herbal supplements and any inhalers.

	<u>MEDICATION NAME</u>	<u>DOSE</u>	<u>FREQUENCY</u>
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			
13			

Patient Name: _____

Date of Birth: _____



Patient Name: _____ DOB: _____ Today's Date: _____

OBSTRUCTIVE SLEEP APNEA SCREENING

STOP- BANG QUESTIONNAIRE

STOP QUESTIONS

- | | | |
|--|-----|----|
| 1. S norring – Do you snore loudly (louder than talking or loud enough to be heard through closed doors)? | Yes | No |
| 2. T ired - Do you often feel tired, fatigued, or sleepy during the daytime? | Yes | No |
| 3. O bserved breathing pattern - Has anyone observed you stop breathing during your sleep? | Yes | No |
| 4. Blood P ressure - Do you have or are you being treated for high blood pressure? | Yes | No |

BANG QUESTIONS

- | | | |
|--|-----|----|
| 5. B MI - BMI more than 35? | Yes | No |
| 6. A ge - Age over 50 year old? | Yes | No |
| 7. N eck Circumference - Is your neck size greater than 40 cm (approx. 15.75 inches)? | Yes | No |
| 8. G ender - Gender Male? | Yes | No |

TOTAL SCORE: _____

EPWORTH SLEEPINESS SCALE

The Epworth Sleepiness Scale is used to determine the level of daytime sleepiness. Use the following scale to choose the most appropriate number for each situation over the past two weeks. Even if you don't usually do this activity, please give your best estimate:

0 = would *never* doze or sleep.

2 = *moderate* chance of dozing or sleeping

1 = *slight* chance of dozing or sleeping

3 = *high* chance of dozing or sleeping

Situation

Chance of dozing/sleeping

• Sitting and reading	0	1	2	3
• Watching TV	0	1	2	3
• Sitting inactive in a public place	0	1	2	3
• Being a passenger in a motor vehicle for an hour or more	0	1	2	3
• Lying down in the afternoon	0	1	2	3
• Sitting and talking to someone	0	1	2	3
• Sitting quietly after lunch (no alcohol)	0	1	2	3
• Stopped for a few minutes in traffic	0	1	2	3

TOTAL SCORE: _____

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