Pulmonary and Sleep Associates of Marin

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ADULT PATIENT MEDICAL QUESTIONNAIRE

Name:	**Date:**
Sex: __M __F **Age:**	**DOB:** **Height:** **Weight:**
Referred by doctor:	**Primary Care doctor:**
Reason for consultation:	
Drug Allergies? Drug Name(s):	Type of reaction:
Pneumonia vaccine? __No __Yes (Year:)	**Code Status**: __Full __No Code
Pain? __No __Yes (level 1-10:)	

Your Medications:

Drug name	Dose	Times taken daily	Drug name	Dose	Times taken daily

Your Past Medical History:

Date of diagnosis	Diagnosis, Medical Problem, or Hospitalization

Your Past Surgical History:

Date	Type of Surgery	Date	Type of Surgery

Do you or does anyone in your family have a history of the following conditions? (Check boxes.)

Condition	Personal History	Family History	Which Relative?
Allergies			
Asthma			
Emphysema (or alpha-1 anti-trypsin deficiency)			
Blood clot in leg veins or in the lungs			
Cystic Fibrosis/Bronchiectasis			
Lung Cancer/Other cancer:			
High Blood Pressure/Heart Failure/Heart Attack			
Stroke			
Diabetes			
Hypothyroidism			
Heartburn/Acid Reflux			
Depression/Anxiety			
Insomnia			
Sleep Apnea			
Restless Legs Syndrome			
Narcolepsy			
Abnormal Behaviors in Sleep			
Other not detailed above? Please specify:			

Your Social History/Habits:

Exercise Habits (type/frequency): _____

Tobacco Use:__Never __Former __Current Smoker; # cigs/day____year began____year quit_____

Alcohol Use: ___No ___Yes #glasses/day____ specify:_____

Caffeine Use: ___No ___Yes #cups/day_____ specify:_____

Illicit Drug Use: ___No ___Yes If yes, specify:_____

Environmental history (Circle if applies):

HOME Exposures: cats, dogs, birds, farm animals, carpets, forced-air heating, plants in bedroom, down bedding, water damage, visible mold, humidifier use, hot tub use, sauna use, well water, wood smoke, vineyards, pesticides, Other:_____

WORK Exposures: asbestos, fumes, chemicals, fine dust, mold, Other: _____

Recent Travel (in US or abroad):_____Shift Work? Yes/No Commercial Driver? Yes/No

Place of Birth: _____Where did you grow up? _____

In the past 2 weeks, have you had any of the following symptoms (Circle if applies):

Weight Change	Confusion	Nasal Congestion	Leg swelling
Loss of Appetite	Memory Problems	Sinus pressure/pain	Heartburn/Reflux
Fevers/Chills/Sweats		Cough	Abdominal Pain
Vision Change	Incoordination/Falls	Shortness of Breath	Nausea/Vomiting
Headaches	Numbness/Tingling	Wheezing	Urinary Problems
Dizziness	Muscle weakness	Chest Pain	Rashes
Tremor	Anxiety/Depression	Palpitations	Joint/Muscle Pain

IF YOU HAVE A SLEEP PROBLEM, PLEASE COMPLETE THE FOLLOWING (pages 3 and 4):

How long have you had your sleep problem? ___<1 mo ___1-3 mo ___3-6 mo ___ 6-11 mo _____ year(s)
What time do you go to bed? _____ How long does it take you to fall asleep? _____
What do you do if you cannot fall asleep? _____
How many times on average do you wake up in the night? _____ How much time is spent awake? _____
What time do you get out of bed in the morning? _____
On average, how much sleep do you think you need to feel rested? _____
What is your preferred sleep timing? ___ Night Owl ___ Morning Lark ___ Neither/Mixed

	No	**Yes**
If you have a bed partner, do you disturb his or her sleep?		
Do you snore?		
Has someone witnessed you stop breathing when you sleep?		
Do you wake up gasping or choking or with shortness of breath?		
Do you have a dry mouth at night or in the morning upon awakening?		
Do you grind or clench your teeth at night?		
Do you have night sweats?		
Do you have heartburn or reflux at night?		
Do you get up during the night to urinate?		
Do you wake up with palpitations or chest pain?		
Do you wake up with a headache in the morning? Describe your headache:_____		
Does body pain wake you up at night?		
Are you a restless sleeper?		
Do you have trouble falling or staying asleep?		
If you wake up at night, is it hard to fall back asleep?		
Do you need sleep aids to help you to fall asleep or stay asleep? Which? _____		
Do you get too little sleep at night?		
At bedtime, do you have racing thoughts, worry, or anxiety related to falling asleep?		
Do you consider yourself a light sleeper, easily disturbed by light or noise?		
Do you wake up without an alarm?		
Do you stay in bed after you have woken up?		
Is it difficult to get out of bed due to sleepiness?		
Is your sleep unrefreshing?		
Do you feel sleepy or drowsy during the day?		
Do you feel fatigued, tired, or have low energy during the day?		
Do you take naps? How many naps and for how long? _____		
Do you find naps to be unrefreshing?		
Do you have problems with concentration, attention, or short-term memory?		
Do you have problems with anxiety, depression, or irritability?		
Have you had any recent loss of interest, feelings of guilt, decreased energy, or appetite changes?		

Have you had any recent thoughts of hurting yourself or anyone else?		
Do you have restless legs (crawling, aching, or inability to stay still)? How severe is it? _____ Do you take medications? _____		
Do you kick your legs at night or disturb your bed partner by moving while you sleep?		
Do you have any history of sleep-walking, sleep talking, groaning, sleep eating, dream enactment such as hitting or kicking, or other behaviors in sleep?		
Do you wake up screaming, confused, or violent?		
Do you have frequent nightmares?		
Do you experience hallucinations while falling asleep or upon awakening?		
Do you ever experience paralysis when falling asleep or waking up?		
Have you ever experienced muscle weakness associated with extreme emotions (i.e., laughter, anger, or surprise that causes knee buckling, jaw slackness, or full collapse)?		
As a child, did you have bedwetting, sleepwalking, night terrors, ADHD, or other sleep problems?		
Do you work graveyard, evening, late, or rotating shifts?		
Have you ever fallen asleep or almost fallen asleep while driving? How many times? _____ Did it cause an accident? _____		
Do you drive a semi-truck or fly an airplane for business or pleasure?		
Have you gained weight in the last year? How much? _____		
Have you ever used biofeedback, meditation, guided imagery, relaxation, breathing, or other techniques to aid your sleep?		
For women, have you gone through menopause? For men, do you have erectile dysfunction?		
Does your sleep problem interfere with daily functioning?		
Are you concerned about the long-term consequences of your sleep problem?		

EPWORTH SLEEPINESS SCALE:

This scale helps us determine how likely you are to doze off in the following situations. It refers to your usual way of life in recent times. Use the following scale to **choose the most appropriate number** for each situation.

0=no chance of dozing
1=slight chance of dozing
2=moderate chance of dozing
3=high chance of dozing

SITUATION	**0-3**
Sitting and reading	
Watching TV	
Sitting inactive in a public place (i.e., theater or meeting)	
As a passenger in a car for an hour without a break	
Lying down to rest in the afternoon	
Sitting and talking to someone	
Sitting quietly after a lunch without alcohol	
In a car, while stopped for a few minutes in traffic	

Total= _____