Metroplex Pulmonary & Sleep Center, P.A.

OFFICE HISTORY FORM

Name: ___________________________ **Date:**_____________________
Date of Birth: _____________________ **Age:**___________________

Describe the current medical problem/reason for today's visit: _____________________
____
Have you had any recent x-rays or lab tests, relating to this problem? ___Yes ___No
If yes, when and where were they done? _______________________________
Who is your primary care physician? ____
Referring Physician? ____
Have you ever diagnosed with the following?

___ Asthma __ Hear Attack __ Sleep Apnea __ Thyroid Disease
___ Chronic Bronchitis __ Stroke __ Kidney Disease __ High Cholesterol
___ Emphysema __ Hypertension __ Gastric Ulcers __ Congestive Heart
___ Pneumonia __ Diabetes __ Hepatitis __ Tuberculosis

Past Surgical History:____
Other Hospitalzations:____
Are you allergic to any medications? Name:____________________________________
Current Medications: Please list all medications you are currently taking
__________________, ____________________, ________________, ________________,
__________________, ____________________, ________________, ________________.
Are you using : Oxygen_________, CPAP______________, Nebulizers_____________
Do you smoke? __Yes __No
If so, how many packs a day? _________
If you have quit ,when __________
Do you consume alcohol on a regular basis? __Yes __No
If so, how much? ___________

Have you ever had the flu vaccine? __Yes __No
Have you ever had the pneumonia vaccine? __Yes __No

What kind of work do you do?____
Are you married? __Yes __No
Do you any children? __Yes __No
Do you have pets at home? __Yes __No
Have you been exposed to dust, fumes, asbestos? __Yes __No

Please list any family medical history _______________________________________
____

Do you get short of breath? __Yes __No
When did you first notice shortness of breath? __ Days __ Wks __ Months __ Yrs
Has the shortness of breath gotten worse over time? __Yes __No
If so, has it gotten worse: __ slowly _____ suddenly
What causes shortness of breath ____

Does anything else make you short of breath? ______________________________
Do you feel shortness of breath when you first lie down at night? __Yes __No
When lying down do you prop your head up to breath comfortably? __Yes __No
Do you wake up at night short of breath? __Yes __No
Do your feet swell? __Yes __No
Do you wheeze? __Yes __No
Do you wake up wheezing at night? __Yes __No
What makes you wheeze?
Do you cough? __Yes __No
How long have you been coughing? ____
Does anything cause you to cough or worsen it ? ______________________________
Is the cough worse at certain times of the day? ________________________________
Is the cough worse at night wake you up at night? ______________________________
Do you bring up sputum? __Yes ___No
What color is your sputum: Circle one: clear, white, gray, yellow, green
On average how much sputum do you cough up during a day? ___________________
Have you ever noticed blood in your sputum? __Yes __No
Do you have pain/discomfort in your chest? __Yes __No
If so, what area of chest: ____
What type of pain: a. sharp b. dull c. stabbing d. constant e. intermittent
Does the pain shift to another part of your body? __Yes __No
Is the pain worse with exercise? __Yes __No
Is the pain worse with deep breathing? __Yes __No
Have you ever been exposed to Tuberculosis? __Yes __No
Do you snore? __Yes __No
Do you stop breathing at night? __Yes __No
Do your legs ache at night? __Yes __No
Do you difficulty falling asleep? __Yes __No
What time do you go to bed: ___________ and wake up ____________
Do you feel tired in the morning? __Yes __No
Do you sweat at night? __Yes __No
Do you have: Fevers______, chills___________, or night sweats________?
Do you suffer from: Headaches__ Seizures__ Passing out spells __ Dizziness ________?
Do you have: Nausea______ Vomiting___ Diarrhea____ Reflux____?
Do you have: Arthritis_____ Muscle Aches__________?
Did you notice: Weight loss_______ Weight Gain_______ Fatigue ____________

Patient Signature _____________________________ Date ______________

Physician Signature __________________________ Date ______________

SLEEP LAB HISTORY

INSTUCTIONS:

Circle YES or No or FILL in the blanks as appropriate.
Circle the answer NO if the problem is very infrequent.
Place an X beside any question you don not understand or cannot answer by a simple "yes" or "no"

The following questions are about complaints and problems associated with sleep at night.

1.	What time do you usually go to bed?	**am/ pm**
2	What time do you usually get out of bed?	**am/ pm**
3	How long does it take you to fall asleep?	
4	**Do you have a problem with falling asleep at night?**	**Yes/ No**
5	**Do you feel that the quality of your sleep is unsatisfactory- that is no matter how much sleep you get, you do not wake up feeling rested? NON_REFRESHING SLEEP**	**Yes/ No**
6	**On average, how many hours of sleep do you get each night?**	**Yes/ No**
7	**How many times do you awaken each night and for what reason?**	**Yes/ No**
8	**Do you have trouble getting back to sleep?**	**Yes/ No**
9	**How long are you awake all together during the night?**	**Yes/ No**
10	**Have you ever been told you snore?**	**Yes/ No**
11	**Do you sometimes wake up feeling like you are choking or gasping for breath?**	
12	**Do you have a dry mouth when you get up?**	
13	**Do you urinate more than once during the night?**	**Yes/ No**
14	**Do you sweat excessively during sleep?**	
15	**Is your sleep often "restless" or "disturbed"?**	
16	**Are you bothered by leg cramps or pains in the calf during the night?**	**Yes/ No**
17	**Do you have" creeping, crawling, difficult to describe feelings" in your arms and legs that are relieved by moving or rubbing them?**	**Yes/ No**
18	**Do you nap during the day?**	**Yes/ No**
19	**Do you feel extremely drowsy or sleepy during the day?**	**Yes/ No**
20	**Have you ever been in unusual or embarrassing situations because you felt extremely sleepy or were having trouble concentrating?**	**Yes/ No**
21	**Do you feel paralyzed when falling asleep or as you wake up?**	**Yes/ No**
22	**Do you have attacks of sudden physical weakness or paralysis during the day when laughing, angry or in other emotional situations?**	**Yes/ No**
23	**Do you have headaches at night or in the morning?**	**Yes/ No**
24	**Do you consider that your sleep/ wake schedule is unusually irregular?**	**Yes/ No**
25	**Do you have an occupation that involves shift-work?**	**Yes/ No**
26	**Did you have a worse problem with your sleep at some other time in your past life?**	**Yes/ No**