

PATIENT PERSONAL HISTORY

Name _____ Date _____

Chief Complaint: What is the **main concern** you are here today to discuss?

When did you **first** notice this problem? _____

Describe the symptoms, if any, **when** they occur, and **how severe** they are on a scale of 0-10, 0=none and 10=very, very severe _____

Do you use oxygen? **Yes No** How much and when? **Resting:** _____ **Sleeping:** _____ **Exertion:** _____

Do you use a CPAP or BIPAP? **Yes No** What are the settings? _____

Date of your last sleep study: _____ Where was it done: _____

Do you have an Advanced Directive (Living Will) or a code status? **Yes No**
 What does it state? _____

Do you have a P.O.A. for medical decisions? **Yes No**

SOCIAL AND ENVIRONMENTAL HISTORY

Occupation or former occupation: _____

Any toxic or hazardous exposures? _____

Check the box of the appropriate answer. **Y = Yes N = No OC = Occasionally**

	Y	N	OC		Y	N	OC
Regular exercise				Drink coffee, tea, cola			
Smoke or use tobacco now				How much coffee, tea, cola:			
Use tobacco in the past				Drink Alcohol			
Date Tobacco Started:				What Kind Alcohol:			
Date Tobacco Stopped:				How Much Alcohol:			
List all Pets:							

Name _____ Date _____

TRAVEL

Have you traveled out of the country in the past 12 months? YES; list places below NO

REVIEW OF SYSTEMS - Check the box of the appropriate answer regarding your **CURRENT** symptoms.

Use approx. dates where required. **Y** = Yes **N** = No **OC** = Occasionally

CONSTITUTIONAL	Y	N	OC	EARS, NOSE AND THROAT	Y	N	OC
Tiredness				Had a change in hearing			
Felt Depressed				Wearing hearing aids			
Gained Weight				Ears ringing			
Lost Weight				Sinus trouble			
Trouble sleeping				Hoarseness			
Lots of stress				Lump in your throat			
Fever				Painful swallowing			
EYES	Y	N	OC	RESPIRATORY	Y	N	OC
Had glaucoma				Breathless at rest			
Eye pain				Breathless with exertion			
Vision trouble				Cough			
Spots in vision				Cough with sputum or phlegm			
Wear glasses				Wheezing			
CARDIOVASCULAR	Y	N	OC	Excessive Snoring			
Chest pain or tightness				Gasping Spells			
Abnormal heart rhythm				Chest pain with deep breathing			
Heart murmur				Exposure to Tuberculosis (TB)			
Leg cramps w/ walking				Date of last TB skin test:			
Abnormal - EKG				Date of last Chest X-Ray:			
Date of Last EKG:				GENITOURINARY	Y	N	OC
Blue or very white fingers				Pain with Urination			
Awaken to catch breath				Urinate very Frequently			
Sleep sitting up to breathe				Get up at night to urinate			
GASTROINTESTINAL	Y	N	OC	Have trouble holding urine			
Heartburn				MEN	Y	N	OC
Nausea				Impotence			
Vomiting				Prostate trouble			
Vomiting Blood				WOMEN	Y	N	OC
Constipation				Breast Lump			
Hemorrhoids				Hot Flashes			
Abdominal Pain				Change in periods			
Diarrhea				Nipple discharge			
Use laxatives				Date of last Mammogram:			
Blood in stools				Date of last Pap Smear:			
Black stools				Date of last Period:			
Hepatitis or jaundice in the past							
Date of last proctoscopy:							

Name _____

Date _____

SKIN - INTEGUMENTARY	Y	N	OC	MUSCULOSKELETAL	Y	N	OC
Changing blemishes				Joint pains			
Skin lesions				Known tendonitis or bursitis			
Warts				Feet swelling			
Rash				Walk with limp			
NEUROLOGIC	Y	N	OC	Back pain			
Headaches				Foot trouble			
Dizzy spells				HEMATOLOGIC – LYMPHATIC	Y	N	OC
Light headedness				Anemia			
Bad memory				Blood transfusion			
Fainting				Date of blood transfusion:			
Seizures				Easy bruising			
Numbness				Free bleeding			
Unsteady walking				Swollen lymph glands			
Slurred speech				ALLERGIC – IMMUNOLOGIC	Y	N	OC
PSYCHIATRIC	Y	N	OC	Food allergy			
Depression				Seasonal runny nose			
Anxious				Hives			
Change in personality				Frequent pneumonias			
Crying spells				Removal of spleen			
Early morning awakening				Had pneumonia vaccine			
Hearing imaginary voices				Use of prednisone or steroids			
				ENDOCRINOLOGIC	Y	N	OC
				History of Diabetes			
				History of Thyroid problems			
				Excessive Thirst			
				Night time Urination			

Do **NOT** complete if you completed the sleep disorders questionnaire. (green paperwork)

SLEEP	Y	N	OC
Do you wake up feeling rested?			
Do you have daytime headaches?			
Have you ever been diagnosed with sleep apnea?			
Do you snore?			
Has anyone ever seen you stop breathing while asleep?			