**Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date of Birth:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Section 1: ID Risk Screen**

No Travel History Last 7 Days Last 14 Days Last 21 Days Last 2 Months

Recent Travel Location: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Family Member/Household/Contact Travel History

No Travel History Last 7 Days Last 14 Days Last 21 Days Last 2 Months

Recent Travel Location: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*Contact with person with highly contagious disease (Ebola/MERS/2019-nCoV) AND have one or more of the systems below: Yes No

\*Travel to a country with wide-spread (Ebola/MERS/2019-nCoV) in the past 21 days AND have one or more of the systems below: Yes No

*Ebola Symptoms: Fever, Headache, Weakness, Muscle Pain, Vomiting, diarrhea, Abdominal Pain or Hemorrhage*

*MERS (Middle East Respiratory Syndrome) Symptoms: Fever, Chills/Rigors, Headache, Sore Throat, Cough, Difficulty Breathing, Nausea, Vomiting, Diarrhea, Abdominal Pain or Muscle Pain*

*Zika Symptoms: Macular or Papular Rash, Fever, Arthralgia or Conjunctivitis*

*Some symptoms are not unique for TB. For new or worsening cough, provide patient with a mask.*

*2019-nCov (2019-nCoV Novel Coronavirus) Symptoms: Fever and symptoms of lower respiratory illness (e.g., cough, difficulty breathing)*

Infectious Disease Risk Factors/Symptoms—*(Only if YOU or FAMILY MEMBER has traveled)*

|  |  |  |
| --- | --- | --- |
|  | **Yes** | **No** |
| **Vomiting** |  |  |
| **Diarrhea** |  |  |
| **Abdominal(Stomach Pain)** |  |  |
| **Weakness/Numbness** |  |  |
| **Exposure to Disease** |  |  |
| **Abnormal Breathing** |  |  |
| **Unexplained bruising** |  |  |
| **Joint Pain** |  |  |
| **Abscess** |  |  |
| **Rash** |  |  |

|  |  |  |
| --- | --- | --- |
|  | **Yes** | **No** |
| **Chills** |  |  |
| **Fever** |  |  |
| **Fatigue** |  |  |
| **Headache** |  |  |
| **Runny or Stuffy Nose** |  |  |
| **Sore Throat** |  |  |
| **Difficulty Breathing** |  |  |
| **Shortness of Breath** |  |  |
| **New or Worsening Cough** |  |  |
| **Wheezing** |  |  |

MDRO History Surveillance

|  |  |  |
| --- | --- | --- |
|  | **Yes** | **No** |
| **History of Clostridium Difficile** |  |  |
| **History of Extended Spectrum beta-Lactamase** |  |  |
| **History of MRSA** |  |  |
| **History of Vancomycin-resistant enterococci** |  |  |
| **History of Carbapenem-resistant Enterobacteriaceae** |  |  |
| **Other** |  |  |

Verify droplet, Contact Isolation for Ebola: Yes N/A

\*Verify Airborne, Contact Isolation for MERS/2019-CoV: Yes N/A

Does the patient have any of the following conditions that compromise the immune system?

|  |  |
| --- | --- |
| ○ None  ○ Acquired immune deficiency syndrome (AIDS)  ○ AIDS related complex (ARC)  ○ Any immunodeficiency syndrome  ○ Chronic Lymphocytic Leukemia (CLL)  ○ Congenital or hereditary immunodeficiency  ○ Human Immunodeficiency Virus (HIV)  ○ Leukemia within 90 days  ○ Lymphocytic Leukemia within 90 days  ○ Marked Neutropenia within 90 days  ○ Myelodysplasia within 90 days | ○ Myelogenic Leukemia within 90 days  ○ Organ Transplant  ○ Pancytopenia within 90 days  ○ Prior hospitalization within 14 days  ○ Radiation therapy within 90 days  ○ Significant neutropenia within 90 days  ○ Systemic chemotherapy within 90 days  ○ Systemic corticosteroid/Prednisone therapy within 90 days  ○ Systemic immunosuppressive therapy within 90 days |

**Section 2: Summary**

Chief Complaint: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Neck Circumference**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_inches

Onset of Symptoms: ­­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Additional Information: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Preferred Language: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Method of Arrival: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Arrived With: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Consent Signed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Onset of Symptoms: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Last Menstrual Period: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Vitals:

BP: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ BP site: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ HR: \_\_\_\_\_\_\_\_\_\_\_ HR Site: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Temp: \_\_\_\_\_\_\_\_\_\_\_\_­­\_ Site: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ RR: \_\_\_\_\_\_\_\_\_ SpO2 %: \_\_\_\_\_\_\_\_\_\_\_\_\_ O2: \_\_\_\_\_\_\_\_\_\_

Measurements:

Height: \_\_\_\_\_\_\_\_\_\_\_\_in/cm Weight: \_\_\_\_\_\_\_\_\_\_\_\_lb/kg Method Weight Obtained: \_\_\_\_\_\_\_\_\_\_\_\_

Head Circumference: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_cm Abdominal Circumference: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_cm Chest Circumference: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ cm

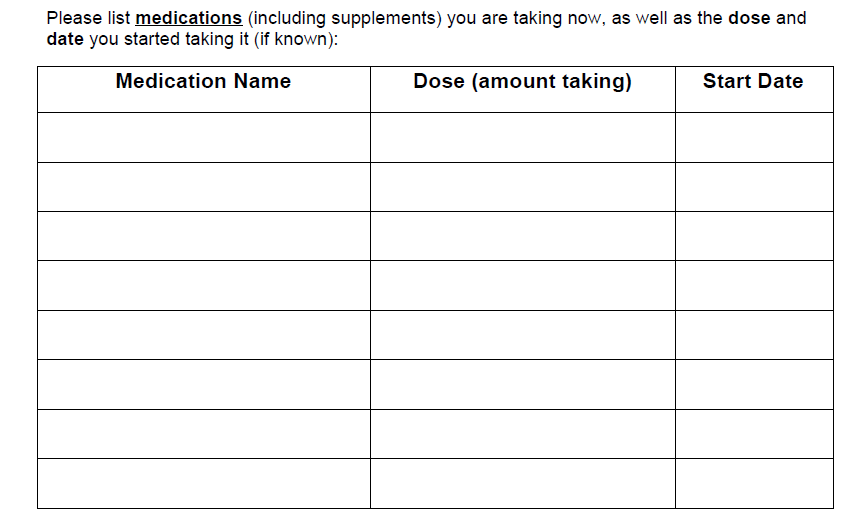
**Section 3: Problems and Visit Diagnosis**

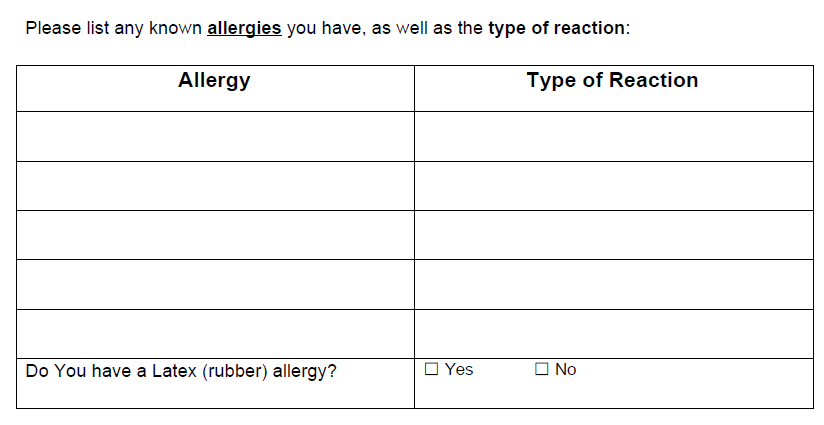
*Diagnosis*: Why are you being seen today? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Past Medical History:

|  |  |
| --- | --- |
| **Date** | **Problem** |
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**Section 4: Medications/Allergies**

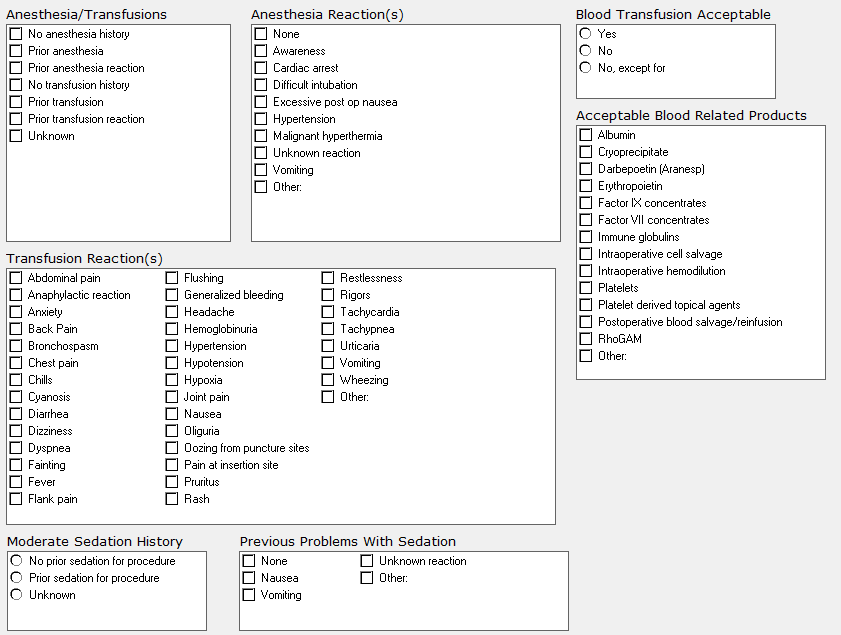




**Section 5: Procedures/Surgeries**

|  |  |
| --- | --- |
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Anesthesia and Transfusions:



**Section 6: Family History**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Relationship: | Mother | Father | Sister | Brother | Grandparent |
| Health Status: |  |  |  |  |  |
| **Cardiovascular:** |  |  |  |  |  |
| Aneurysm |  |  |  |  |  |
| Heart attack |  |  |  |  |  |
| High blood pressure |  |  |  |  |  |
| **Endocrine/Metabolic:** |  |  |  |  |  |
| Diabetes Mellitus Type I |  |  |  |  |  |
| Diabetes Mellitus Type II |  |  |  |  |  |
| Thyroid Disease |  |  |  |  |  |
| **Eye:** |  |  |  |  |  |
| Cataract |  |  |  |  |  |
| Glaucoma |  |  |  |  |  |
| **Gastrointestinal:** |  |  |  |  |  |
| GERD-Gastro-esophageal reflux disease |  |  |  |  |  |
| Hiatal Hernia |  |  |  |  |  |
| Irritable bowel syndrome |  |  |  |  |  |
| Liver disease |  |  |  |  |  |
| Peptic ulcer disease |  |  |  |  |  |
| **Genitourinary:** |  |  |  |  |  |
| Enlarged prostate |  |  |  |  |  |
| Incontinence |  |  |  |  |  |
| Kidney disease |  |  |  |  |  |
| Prostate cancer |  |  |  |  |  |
| **Hematologic:** |  |  |  |  |  |
| Bleeding disorder |  |  |  |  |  |
| Hemophilia |  |  |  |  |  |
| **Immunologic:** |  |  |  |  |  |
| AIDS |  |  |  |  |  |
| Autoimmune disease |  |  |  |  |  |
| **Musculoskeletal:** |  |  |  |  |  |
| Acute arthritis |  |  |  |  |  |
| Back Injury |  |  |  |  |  |
| Back Pain |  |  |  |  |  |
| Fibromyalgia |  |  |  |  |  |
| Osteoporosis |  |  |  |  |  |
| Rheumatism |  |  |  |  |  |
| **Neurologic:** |  |  |  |  |  |
| Alzheimer’s Disease |  |  |  |  |  |
| Migraine |  |  |  |  |  |
| Seizure |  |  |  |  |  |
| Stroke |  |  |  |  |  |
| TIA |  |  |  |  |  |
| Tremor |  |  |  |  |  |
| **Oncological:** | Mother | Father | Sister | Brother | Grandparent |
| Bladder Cancer |  |  |  |  |  |
| Bone Tumor |  |  |  |  |  |
| Brain Tumor |  |  |  |  |  |
| Breast Cancer |  |  |  |  |  |
| Colon Cancer |  |  |  |  |  |
| Prostate Cancer |  |  |  |  |  |
| Uterus Cancer |  |  |  |  |  |
| Lung Cancer |  |  |  |  |  |
| Cervix Cancer |  |  |  |  |  |
| Ovary Cancer |  |  |  |  |  |
| Hodgkin’s Disease |  |  |  |  |  |
| Leukemia |  |  |  |  |  |
| Lymphoma |  |  |  |  |  |
| Non-Hodgkin’s Lymphoma |  |  |  |  |  |
| Skin Cancer |  |  |  |  |  |
| **Psychiatric:** |  |  |  |  |  |
| Addiction |  |  |  |  |  |
| Alcohol Abuse |  |  |  |  |  |
| Anxiety |  |  |  |  |  |
| Bipolar Disorder |  |  |  |  |  |
| Dementia |  |  |  |  |  |
| Depression |  |  |  |  |  |
| Schizophrenia |  |  |  |  |  |
| Suicidal thoughts |  |  |  |  |  |
| **Respiratory:** |  |  |  |  |  |
| Asthma |  |  |  |  |  |
| COPD |  |  |  |  |  |
| Sleep Apnea |  |  |  |  |  |
| **Genetic:** |  |  |  |  |  |
| Celiac Disease |  |  |  |  |  |
| Cystic Fibrosis |  |  |  |  |  |
| Down’s Syndrome |  |  |  |  |  |
| Muscular dystrophy |  |  |  |  |  |
| Exposures: |  |  |  |  |  |
| Alcohol User |  |  |  |  |  |
| Substance User |  |  |  |  |  |
| Tobacco User |  |  |  |  |  |
| **OTHER:** |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |

**Section 7: Social History**

Have you been hospitalized outside the US in past 6 months? Yes No

Patient shows signs/symptoms of neglect? Yes No

**History Assessed:** Yes No

Have you used Tobacco anytime during the past 30 days? Yes No

**Alcohol Use:** Current Past Never

Type: Beer Wine Liquor Other:

Frequency: 1-2 x year 1-2 x month 1-2 x week 3-5 x week Daily Several x Day

Tobacco Use:

Current Status unknown Unknown if ever smoked Current every day smoker

Current some day smoker Former smoker Never smoker

Heavy tobacco smoker Light tobacco smoker

**Electronic Cigarette Use:**

Never Use, within 90 days Former use, greater than 90 days

Refused screening Unknown/Not Obtained Other

Type: ­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Uses/Inhales per day: ­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Substance Use**: Current Past Never

Type: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Caffeine Use**: Yes No

Type: ­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Caffeine per day: ­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Marital Status**: Married Single Divorced Widowed Other: ­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_

Number of Children: ­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Living Arrangements:**

Alone Family/Significant Other Assisted Living Other: \_\_\_\_\_\_\_\_\_

Do you have daily help needed for self-care? Yes No Name of Caregiver:\_\_\_\_\_\_\_\_\_

**Activities of Daily Living:** Any difficulty with? Speech or Communication Memory

Speech or Communication Memory Bathing Household Duties

**Physical Activity:** Exercise Type: ­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Frequency: ­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Section 8: Morse Fall Risk**

History of Falling Immediate or Within Last 3 Months: Yes No

Presence of Secondary Diagnosis: Yes No

Use of Ambulatory Aid: Furniture Crutches, cane, walker None, bedrest, wheelchair

IV/Heparin Lock: Yes No

Gait/Transferring: Impaired Weak Normal, bedrest, immobile

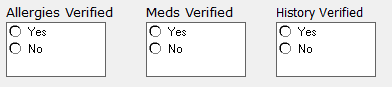
Mental Status: Forgets Limitations Oriented to own ability

**Section 9: Advance Directives**

Advance Directives: Yes No

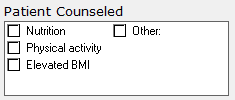
Patient Wishes to Receive Further Information on Advance Directives: Yes No

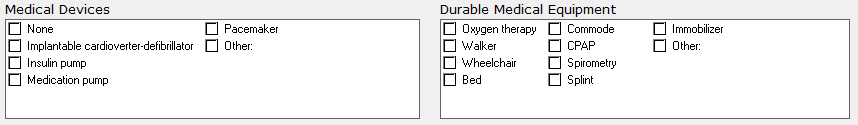
**Section 10: Health Status**



Immunizations Current: Yes  No  Non Received  Unknown  Vaccine Recommended

* Other





**Section 11: Depression Screening**

**PHQ2-PHQ9 Screening:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Over the past 2 weeks, how often have you been bothered by any of the following problems? | Not At All | Several Days | More than ½ the Days | Nearly Every Day |
| 1. Little interest or pleasure in doing things: | 0 | 1 | 2 | 3 |
| 1. Feeling down, depressed or hopeless: | 0 | 1 | 2 | 3 |
| **If you answered 0 to the questions above- stop** | | | | |
| 1. Trouble falling asleep, staying asleep or sleeping too much: | 0 | 1 | 2 | 3 |
| 1. Feeling tired or having little energy: | 0 | 1 | 2 | 3 |
| 1. Poor appetite or overeating: | 0 | 1 | 2 | 3 |
| 1. Feeling bad about yourself: | 0 | 1 | 2 | 3 |
| 1. Trouble concentrating: | 0 | 1 | 2 | 3 |
| 1. Moving or speaking so slowly: | 0 | 1 | 2 | 3 |
| 1. Thoughts that you would be better off dead or of hurting yourself in some way: | 0 | 1 | 2 | 3 |
| 1. Difficulty at work, home, or getting along with others: | 0 | 1 | 2 | 3 |
| Column Totals: |  |  |  |  |
| Add Totals Together: | | | | |
| 1. If you checked off any problems, how difficult have those problems made it for you to do your work, take care of things at home, or get along with other people?   Not Difficult at all Somewhat Difficult  Very Difficult Extremely Difficult | | | | |

**Adult Questionnaire - Sleep Clinic**

Please completely fill in the circles which best describe your current condition. Please answer all questions. Thank you

**Pulmonary:**

Shortness of breath at rest

Shortness of breath with exercise

Frequent cough

Coughing up blood

Chest pain

Wake up at night short of breath

Recurrent chest infections

Exposure to tuberculosis

Wheezing

Blood clot in legs or lungs

**Cardiac:**

High blood pressure

Heart attack

Leg swelling

Heart racing or thumping

Rheumatic fever

Needs to sleep on 2 or more pillows

High cholesterol

**Constitutional symptoms:**

Fever

Night sweats

Chills

Weight loss

**Musculoskeletal:**Muscle weakness  
Joint pain  
Joint swelling

**Psychiatric:**Depression  
Anxiety  
Poor sleep  
Snoring  
Morning headaches or awakening  
Excessive sleep during day  
Panic attacks

No

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**Gastrointestinal:**

Trouble swallowing

Choking on food

Heartburn

Abdominal pain

Nausea

Vomiting

Diarrhea

Ulcers

Jaundice

**Renal:**

Blood in urine

Urinary tract infections

Kidney stones

Frequent urination at night

Painful urination

**Neurologic:**

Stroke

Migraines

Frequent headaches

Numbness or tingling

Seizure

Dizziness

Imbalance or unsteadiness

Vertigo

**Hematology/Oncologic:**  
Anemia  
Cancer  
Bleeding tendency  
Blood transfusion  
  
**ENT:**  
Blurred vision  
Decreased hearing  
Frequent sore throat  
Sinus infections  
Hay fever  
Hoarseness

Yes

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**New Patient Adult Sleep Medicine Questionnaire – Sleep Clinic**

|  |  |  |  |
| --- | --- | --- | --- |
| **Epworth Sleepiness Scale** | | | |
| How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired?  Use the scale below to choose the most appropriate number for each situation.  0 = would **never** doze 1 = **slight** chance 2 = **moderate** chance 3 = **high** chance | | | |
| **Situation:** | **Chance of Dozing**  **0 1 2 3** | | |
| Sitting and reading |  | | |
| Watching TV |  | | |
| Sitting inactive in a public place (e.g., movie theater or meeting) |  | | |
| As a passenger in a car for an hour without a break |  | | |
| Lying down to rest in the afternoon when circumstances permit |  | | |
| Sitting and talking to someone |  | | |
| Sitting quietly after lunch without alcohol |  | | |
| In a car while stopped for a few minutes in traffic |  | | |
| **IF YOU ARE ON CPAP/BIPAP PLEASE ANSWER THE FOLLOWING QUESTIONS:** | | | |
| Are you wearing a full face, over the nose, under the nose, or nasal pillow? (circle one)  Does your mask fit well? Are you wearing a chin strap? | | **YES** | **NO** |
| Is your mask leaking?  If yes, where on your face is the leak occurring? | | **YES** | **NO** |
| Are you choking, gasping, snoring or short of breath while wearing your mask? | | **YES** | **NO** |
| Are you experiencing air in your stomach that causes bloating or gassiness? | | **YES** | **NO** |
| Are you experiencing dry mouth? | | **YES** | **NO** |
| How long does it take you to fall asleep at night? \_\_\_\_\_\_\_\_ | |  |  |
| How many times do you wake up at night? \_\_\_\_\_\_\_\_\_\_  List causes for awakenings: | |  |  |
| How many hours do you sleep at night? Bedtime: Wake time: | |  |  |
| Do you feel more refreshed in the morning upon waking? | | **YES** | **NO** |
| Are you napping? | | **YES** | **NO** |
| Are you exercising? | | **YES** | **NO** |
| Are you working on weight loss? | | **YES** | **NO** |
| Are you taking sleep aids? | | **YES** | **NO** |
| Are you on oxygen at night? | | **YES** | **NO** |
| Are you being treated for Restless Leg Syndrome? | | **YES** | **NO** |
| How long have you been in PAP therapy? | |  |  |
| What concerns do you have about your PAP therapy? | |  |  |

In your own words, please describe the main reason for coming to clinic today/Sleep Study:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you had a sleep study or sleep evaluation before? If so, specify when and where:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Symptom Checklist**

|  |  |  |
| --- | --- | --- |
| **Fatigue/Sleepiness** | **Yes** | **No** |
| I struggle to stay awake or feel tired during the day. |  |  |
| I have fallen asleep while driving. |  |  |
| I have difficulty with memory or concentration. |  |  |
| **Obstructive Sleep Apnea (OSA)** | | |
| I snore or have been told I snore. |  |  |
| I have experienced choking, shortness of breath, or gasping during sleep. |  |  |
| I avoid sleeping on my back. |  |  |
| I struggle with nasal congestion. |  |  |
| I experience leg swelling. |  |  |
| I wake at night to urinate. |  |  |
| Someone in my family has sleep apnea. |  |  |

|  |  |  |
| --- | --- | --- |
| **Sleep Hygiene** | **Yes** | **No** |
| My bedtime is \_\_\_\_\_\_\_\_\_\_\_.  My wake time is \_\_\_\_\_\_\_\_\_\_\_\_. I sleep\_\_\_\_\_ hours per night. | | |
| I feel refreshed and rested when I wake in the morning. |  |  |
| I struggle to fall asleep.  What prevents you from falling asleep? (racing thoughts, pain, restless legs, etc)  How long does it take you to fall asleep? |  |  |
| I have or currently use medications to help me fall sleep.  Please list what you have/are taking: |  |  |
| I wake multiple times during the night.  If yes, list the reasons that wake you up: |  |  |
| I nap intentionally or accidentally fall asleep during the day. |  |  |
| I sleep in my bed at night. |  |  |
| I watch television or use electronics in bed. |  |  |
| I sleep with pets. |  |  |
| I work in my bedroom. |  |  |
| My bedroom is noisy or uncomfortable. |  |  |
| **Excessive Daytime Sleepiness (EDS)** | | |
| I have felt paralyzed while waking up or falling asleep. |  |  |
| I have felt weakness in my face or knees when laughing or with strong emotion. |  |  |
| I experience dream like hallucinations when falling asleep or waking up. |  |  |
| I have a history of depression. |  |  |
| I have chronic pain.  What medications do you use for pain? |  |  |
| **Movement Disorders** | | |
| I have restlessness or discomfort in my legs at night. |  |  |
| I have a history of sleep walking, sleep talking, sleep eating, or acting out in my dreams |  |  |
| I clench or grind my teeth at night. |  |  |
| I have nightmares. |  |  |

**Medical Providers**

|  |  |  |
| --- | --- | --- |
| **What Providers Are You Seeing Or Have You Seen? Who When** | | |
| Primary Care Provider |  |  |
| Cardiologist |  |  |
| Pulmonologist |  |  |
| Neurologist |  |  |
| Oncologist |  |  |
| Other Specialty |  |  |
| Other Specialty |  |  |

**Have you had any of the Following Tests**

|  |  |  |
| --- | --- | --- |
| **TEST Where When** | | |
| Pulmonary Function Test (breathing tests) |  |  |
| Echocardiogram (ultrasound of heart) |  |  |
| Lab work in the Last 2 Years |  |  |
| Overnight Oximetry Tests |  |  |
| EKG |  |  |

**Review of Systems**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Pulmonary** | **Yes** | **Constitutional** | **Yes** | **Renal** | **Yes** |
| Shortness of breath at rest |  | Fever |  | Blood in urine |  |
| Shortness of breath with exercise |  | Night Sweats |  | Frequent urination at night |  |
| Frequent Cough |  | Chills |  | Painful urination |  |
| Waking up at night short of breath |  | Weight loss |  |  |  |
| Wheezing |  |  |  | **Neurologic** |  |
| Blood clots |  | **Gastrointestinal** |  | Migraines or headaches |  |
|  |  | Trouble swallowing |  | Numbness or tingling |  |
| **Cardiac** |  | Heartburn |  | Dizziness |  |
| Chest pain |  | Abdominal pain |  | Imbalance/unsteadiness |  |
| Leg swelling |  | Nausea |  | Vertigo |  |
| Heart racing or thumping |  | Vomiting |  |  |  |
| Sleeping on 2+ pillows |  |  |  | **Psychiatric** |  |
|  |  | **Musculoskeletal** |  | Depression |  |
| **ENT** |  | Muscle weakness |  | Anxiety |  |
| Frequent sore throat |  | Joint pain |  | Poor Sleep |  |
| Sinus infections |  | Joint swelling |  | Snoring |  |
| Hay fever |  |  |  | Morning headaches |  |
| Dry Mouth |  | **Hematology/Oncologic** |  | Sleep during the day |  |
|  |  | Anemia |  | Panic attacks |  |
|  |  | Bleeding tendency |  |  |  |

Please mark yes **ONLY** to those symptoms you have experienced in the **last 2 weeks**.