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
Chills		
Fever		
Fatigue		
Headache		
Runny or Stuffy Nose		
Sore Throat		
Difficulty Breathing		
Shortness of Breath		
New or Worsening Cough		
Wheezing		

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

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

Section 4: Medications/Allergies

Please list **medications** (including supplements) you are taking now, as well as the **dose** and **date** you started taking it (if known):

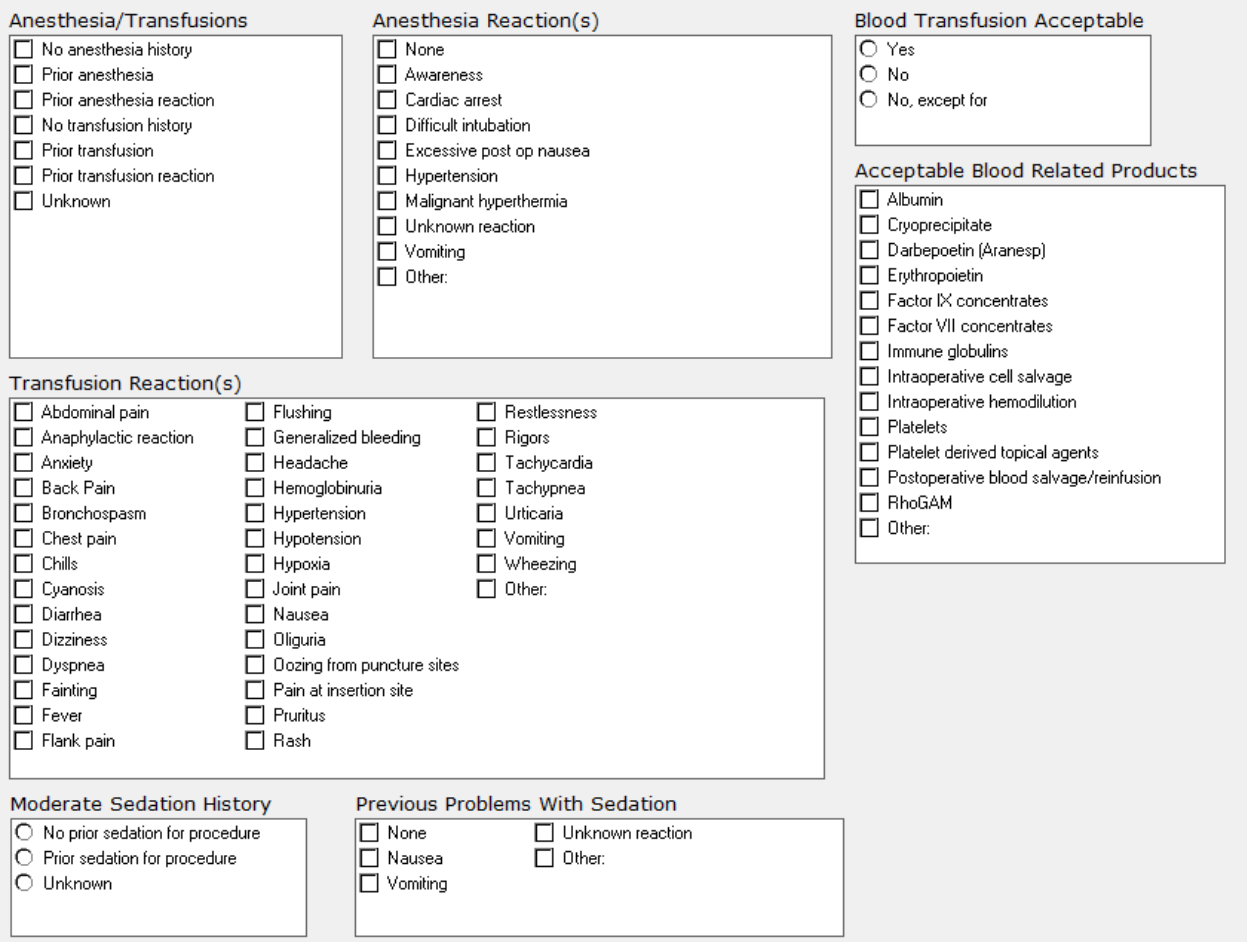
Medication Name	Dose (amount taking)	Start Date

Please list any known **allergies** you have, as well as the **type of reaction**:

Allergy	Type of Reaction
Do You have a Latex (rubber) allergy?	☐ Yes ☐ No

Section 5: Procedures/Surgeries

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

Allergies Verified
○ Yes
○ No

Meds Verified
○ Yes
○ No

History Verified
○ Yes
○ No

Immunizations Current: ☐ Yes ☐ No ☐ Non Received ☐ Unknown ☐ Vaccine Recommended

☐ Other

Patient Counseled
☐ Nutrition ☐ Other:
☐ Physical activity
☐ Elevated BMI

Medical Devices
☐ None ☐ Pacemaker
☐ Implantable cardioverter-defibrillator ☐ Other:
☐ Insulin pump
☐ Medication pump

Durable Medical Equipment
☐ Oxygen therapy ☐ Commode ☐ Immobilizer
☐ Walker ☐ CPAP ☐ Other:
☐ Wheelchair ☐ Spirometry
☐ Bed ☐ Splint

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
2. Feeling down, depressed or hopeless:	0	1	2	3
If you answered 0 to the questions above- stop				
3. Trouble falling asleep, staying asleep or sleeping too much:	0	1	2	3
4. Feeling tired or having little energy:	0	1	2	3
5. Poor appetite or overeating:	0	1	2	3
6. Feeling bad about yourself:	0	1	2	3
7. Trouble concentrating:	0	1	2	3
8. Moving or speaking so slowly:	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way:	0	1	2	3
10. Difficulty at work, home, or getting along with others:	0	1	2	3
Column Totals:				
Add Totals Together:				

11. 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:	Yes	No
Shortness of breath at rest	O	O
Shortness of breath with exercise	O	O
Frequent cough	O	O
Coughing up blood	O	O
Chest pain	O	O
Wake up at night short of breath	O	O
Recurrent chest infections	O	O
Exposure to tuberculosis	O	O
Wheezing	O	O
Blood clot in legs or lungs	O	O
Cardiac:		
High blood pressure	O	O
Heart attack	O	O
Leg swelling	O	O
Heart racing or thumping	O	O
Rheumatic fever	O	O
Needs to sleep on 2 or more pillows	O	O
High cholesterol	O	O
Constitutional symptoms:		
Fever	O	O
Night sweats	O	O
Chills	O	O
Weight loss	O	O
Musculoskeletal:		
Muscle weakness	O	O
Joint pain	O	O
Joint swelling	O	O
Psychiatric:		
Depression	O	O
Anxiety	O	O
Poor sleep	O	O
Snoring	O	O
Morning headaches or awakening	O	O
Excessive sleep during day	O	O
Panic attacks	O	O

Gastrointestinal:	Yes	No
Trouble swallowing	O	O
Choking on food	O	O
Heartburn	O	O
Abdominal pain	O	O
Nausea	O	O
Vomiting	O	O
Diarrhea	O	O
Ulcers	O	O
Jaundice	O	O
Renal:		
Blood in urine	O	O
Urinary tract infections	O	O
Kidney stones	O	O
Frequent urination at night	O	O
Painful urination	O	O
Neurologic:		
Stroke	O	O
Migraines	O	O
Frequent headaches	O	O
Numbness or tingling	O	O
Seizure	O	O
Dizziness	O	O
Imbalance or unsteadiness	O	O
Vertigo	O	O
Hematology/Oncologic:		
Anemia	O	O
Cancer	O	O
Bleeding tendency	O	O
Blood transfusion	O	O
ENT:		
Blurred vision	O	O
Decreased hearing	O	O
Frequent sore throat	O	O
Sinus infections	O	O
Hay fever	O	O
Hoarseness	O	O

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

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

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			