

IMPORTANT

INFORMATION FOR YOUR

SLEEP AND LUNG SPECIALIST

Dear Patient:

Your doctor has asked me to see you because of a possible lung and/or sleep problem. In order to help you with your difficulty, we must obtain a complete history.

Attached you will find questions about your sleep and breathing along with general history questions.

Please download and fill out as completely as possible. If you have difficulty, please ask a family member to assist you.

You may bring the completed form with you at the time of your office visit.

Thank you
Sleep Apnea Specialty Centers of Michigan

Visit our web site at <http://www.sleepapneacenter.com/>

HEALTH HISTORY REVIEW

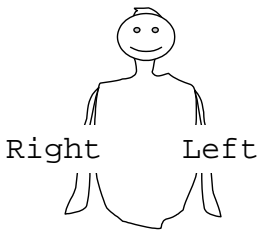
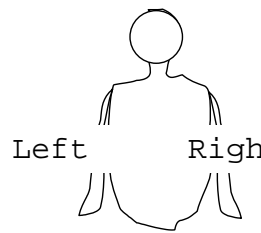
Please answer all questions!

PATIENT NAME _____ AGE: _____ DATE: _____

What medical problem brought you to our hospital/clinic? _____

Name of Person who Completed this Form: _____ Relationship to Patient: _____

Y = YES N = NO NS - Not Sure	Y	N	NS
Do you have shortness of breath? If yes, how long?			
When you were feeling your usual self a few months ago did any of the following make you short of breath: <input type="checkbox"/> walking across the room? <input type="checkbox"/> climbing stairs? <input type="checkbox"/> walking a block?			
How far can you walk without being short of breath?			
Do you wake up at night short of breath or wheezing?			
How many pillows do you sleep on?			
Do you wheeze or make musical sounds when you: <input type="checkbox"/> sit quietly <input type="checkbox"/> enter cold air <input type="checkbox"/> exercise <input type="checkbox"/> get emotionally upset			
How often do you wheeze? <input type="checkbox"/> rarely <input type="checkbox"/> daily <input type="checkbox"/> once a week <input type="checkbox"/> once a month			
When you enter cold air, do you cough or become short of breath?			
Have you had a fever lately? If yes, how high? _____ When did it start? _____			
Have you had chills lately? (The shakes or shivers) If yes, when did they start _____			
Do you have night sweats?			
Have you ever coughed up blood? If yes, when was the last time? _____			
Was the blood streaked in your phlegm?			
Were there any clots in your phlegm?			
How much blood did you cough up? <input type="checkbox"/> teaspoon or less <input type="checkbox"/> tablespoon or more <input type="checkbox"/> half a cup <input type="checkbox"/> cup or more			
Have you had a nose bleed lately?			
Have you had a "cold" recently? If yes, when did it start? _____			
Have you had a sore throat recently? If yes, when did it start? _____			
Have you had a runny nose recently? If yes, when did it start? _____			
Have you had an earache recently? If yes, when did it start? _____			
Do you cough?			
Has your cough increased lately?			
Do you cough up phlegm? If yes, what color is it? <input type="checkbox"/> clear <input type="checkbox"/> white <input type="checkbox"/> yellow <input type="checkbox"/> green <input type="checkbox"/> brown			
Has your phlegm gotten thicker or are you coughing up more phlegm?			
How much phlegm do you cough up in a day? <input type="checkbox"/> teaspoon or less <input type="checkbox"/> tablespoon or more <input type="checkbox"/> half a cup <input type="checkbox"/> more than a cup			
Do you cough or choke when you drink fluids or eat solid foods?			
Do you have a hoarse voice?			
Do you have swollen ankles?			
Have you ever smoked cigarettes? If yes, how old were you when you had your first cigarette? _____			
How old when you had your last cigarette? _____			
How many packs a day did you smoke when you smoked the most, such as at a party? _____			
Have you ever smoked a pipe? If yes, how many pipes full of tobacco did you smoke when you smoked the most?			
Have you ever smoked cigars? If yes, what was the greatest number of cigars you ever smoked in a day?			
Do you have palpitations or unusual beats of your heart?			

Y = YES	N = NO	NS - Not Sure	Y	N	NS
Do you get chest discomfort when you exercise?					
If you answered the above question YES, please answer ALL of the following questions					
Do you ever get chest pain or discomfort? If yes, is it: <input type="checkbox"/> aching <input type="checkbox"/> sharp <input type="checkbox"/> dull <input type="checkbox"/> burning <input type="checkbox"/> pressing or constricting					
Does the chest discomfort increase with breathing?					
Does the chest discomfort increase with twisting or turning of your body?					
When you get the discomfort, do you sweat?					
When you get the discomfort, do you get short of breath?					
Does the chest discomfort go into your: <input type="checkbox"/> jaw <input type="checkbox"/> arm <input type="checkbox"/> back					
Was your chest pain ever evaluated by a doctor? If yes, what was the diagnosis?					
When you get the discomfort, is it always in the same place?					
<p>Please mark the place where you have the most pain</p> <div style="display: flex; justify-content: space-around; align-items: center;"> <div style="text-align: center;">  <p>Right Left</p> <p>Front</p> </div> <div style="text-align: center;">  <p>Left Right</p> <p>Back</p> </div> </div>					
Do you get heartburn regularly?					
Do you have a decreased appetite?					
What did you weigh one year ago? _____ Front _____					
What do you weigh now?					
Have you ever had a problem with drinking alcohol?					
When was your last alcoholic drink? Date: _____					
How many drinks containing alcohol do you drink in a 24 hour period: _____ Weekday _____ Weekend # of Cans of Beer: _____ # of Glasses of Wine: _____ # of Shots of Liquor: _____					
How many cups of coffee do you drink per day?					
Have you ever had a problem with the following drugs? <input type="checkbox"/> sleeping pills <input type="checkbox"/> heroin <input type="checkbox"/> cocaine <input type="checkbox"/> diet pills <input type="checkbox"/> marijuana					
If you are a male, have you ever had homosexual contact?					
Are you excessively sleepy?					
Are you often tired?					
Do people complain about your snoring?					
Are you depressed?					
Do you often feel like crying?					
Do you have thoughts of harming yourself?					
Have you ever seen a psychiatrist or counselor?					
Have you been told by your doctor or psychiatrist that you have any of the following illnesses? <input type="checkbox"/> depression <input type="checkbox"/> manic depression <input type="checkbox"/> schizophrenia <input type="checkbox"/> nervous exhaustion					
When was your last skin test for tuberculosis (TB)? <input type="checkbox"/> Positive <input type="checkbox"/> Negative Date: _____					
Have you ever been on a mechanical ventilator (life support) system? If yes, how many times? _____					

If you need more space, please use the back of this form

LIST YOUR PREVIOUS HOSPITALIZATIONS OR SURGERIES *EXCEPT FOR NORMAL PREGNANCIES*

DATE	Reason for Hospitalization	Name / Location	Name of Physician

LIST ANY DOCTORS YOU HAVE SEEN IN THE PAST FIVE YEARS

DATE	Reason	City	Name of Physician

PLEASE LIST ANY ALLERGIES OR REACTIONS TO MEDICINE

Name of Medicine	Reaction (rash, wheezing, etc.)	Date

LIST BELOW ANY MEDICINE YOU ARE NOW TAKING
(Please include all vitamins, aspirin, pain remedies, laxatives & tranquilizers)

Name of Medicine	Dose	How Often Taken?	Date Started

Do you use home oxygen? Yes _____ No _____ If so, how many liters per minute? _____

Do you use a breathing machine (nebulizer) at home? Yes _____ No _____

Do you use any of the following inhalers?

<u>INHALER</u>	<u>COLOR</u>	Yes ___ / No ___	<u>INHALER</u>	<u>COLOR</u>	Yes ___ / No ___
Atrovent	Green and White	Yes ___ / No ___	Ventolin	Solid Blue	Yes ___ / No ___
Aerobid	Green/Purple	Yes ___ / No ___	Vanceril	Solid Pink	Yes ___ / No ___
Alupent	Blue and White	Yes ___ / No ___	Azmacort	Solid White	Yes ___ / No ___
Proventil	Solid Yellow	Yes ___ / No ___	Serevent	Gray and Green	Yes ___ / No ___
Flovent	Orange/Red	Yes ___ / No ___	Foradil		Yes ___ / No ___

HAVE YOU HAD ANY OF THE FOLLOWING LAB TESTS IN THE PAST FIVE YEARS?

- CAT scan and chest Pulmonary Function Tests Bronchoscopy (lighted tube to look at chest and lungs)

SLEEP HISTORY REVIEW

PLEASE NOTE THAT FURTHER INFORMATION ABOUT SLEEP DISORDERS MAY BE OBTAINED FROM OUR WEB SITE @ sleepapneacenter.com

What problem brought you to our hospital/clinic? _____

How old were you when this problem started? _____

	Y = YES	N = NO	NS - Not Sure	Y	N	NS
What is your height? _____ What is your weight? _____ What is your neck size? _____						
Have you ever been evaluated for sleep problems?						
What are your usual working hours? Begin _____ ٠AM ٠PM End _____ ٠AM ٠PM						
What time do you go to bed and get up on weekdays (or work days)? Go to bed _____ ٠AM ٠PM Get up at _____ ٠AM ٠PM						
Is your bed time quite variable						
Does your job have rotating shifts or night work?						
Do you sleep in the same room with your spouse or significant other?						
Do you do any of the following just prior to turning out the lights and falling asleep? ٠ Read ٠ Watch TV ٠ Have Sex ٠ Take shower or bath ٠ Exercise ٠ Other						
On the average, how many times do you wake up during the night? ٠ 1 ٠ 2 ٠ 3 ٠ 4 ٠ 5 or more						
How do you ordinarily wake up? ٠ Spontaneously ٠ Alarm Clock ٠ Other						
How difficult is it for you to awaken and get out of bed after sleeping? ٠ Very Difficult ٠ Difficult ٠ Sometimes Difficult ٠ No Problem						
Do you take naps during the day?						
How many naps per day (average)? _____ Average length: _____ Hrs. _____ Min.						
Do you wake up from the nap refreshed?						

HOW SLEEPY ARE YOU? (Adapted from Epworth)

Use the following scale to describe your chance of falling asleep

- 0 = No chance of dozing
- 1 = Slight Chance of dozing
- 2 = Moderate change of dozing
- 3 = High Chance of dozing

SITUATION	CHANCE OF DOZING
Sitting and Reading	
Watching TV	
Sitting inactive in a public place (i.e. theater)	
As a car passenger for an hour without a break	
Lying down to rest in the afternoon	
Sitting and talking to someone	
Sitting quietly after lunch without alcohol	
In a car, while stopping for a few minutes in traffic	

Y = YES N = NO NS - Not Sure	Y	N	NS
Do you feel sleepy or drowsy while driving? Is this with: ڤ Short distances ڤ Long Distances			
How long can you drive before you are bothered by sleepiness?			
Have you been in a car accident due to falling asleep at the wheel?			
Have you had a near miss auto accident due to sleepiness?			
Do you fall asleep when you don't want to? When? _____			
Have you even suddenly fallen or experienced sudden body weakness in your legs or jaw while still being aware of your surroundings? If yes, was this ever brought on by any of the following: ڤ Laughter ڤ Fright ڤ Strong Emotion			
Have you ever been told you snore while you sleep? If yes, does the snoring disturb: ڀ Your partner ڀ Someone in next room			
Do you snore every night?			
Have you been told you snore when sleeping: ڤ On your back ڤ Side ڤ Stomach ڤ Sitting			
Has your snoring become progressively worse? If yes, over what period of time?			
Have you been awakened from sleep from your snoring?			
Have you been told that you stop breathing during sleep? If yes, for how long? _____ How many times per hour? _____			
Have you ever experienced weakness or paralysis when: ڤ Going to sleep ڤ Awakening from sleep			
Do you have difficulty breathing through your nose? If yes, check the following: ڤ Daytime ڤ At night ڤ Both			
Do you have episodes where you seem like your are dreaming ڤ During the day? ڤ At bedtime? ڤ On awakening?			
Does anyone in your family have any sleep problems? If yes, what is their relationship and problem:			
Have you ever had funny sensations in your legs before or after sleep? If yes, check the following: ڤ Aching ڤ nervousness ڤ Creeping or crawling ڤ Twitching			
Has anyone ever told you that your arms or legs jerk or twitch while you are asleep?			
Do you wake up in the morning: ڤ with a dry mouth? ڤ sore throat?			

HAVE YOU HAD ANY OF THE FOLLOWING PROBLEMS:

PROBLEM	YES	NO	HOW OFTEN	AGE STARTED	LAST HAPPENED
Sleep Talking					
Sleep Walking					
Teeth Grinding					
Nightmares					
Awaken at night with headache					

FOR MEN

Y = Yes N = No NS = Not Sure	Y	N	NS
Do you have problems getting an erection?			