

Dr. _____

Date of Appointment _____

Time _____

Dear Patient:

Please complete the enclosed questionnaire and bring it with you on the day of your office visit. Please bring all chest x-ray and CT scan films with you along with all medical records that pertain to this appointment.

If you have any questions, please feel free to contact us at (813) 974-7824.

Thank you for choosing us to serve your healthcare needs.

Department of Internal Medicine
Pulmonary, Critical Care and Sleep Disorders Medicine

Patient Name: _____
Last First MI

Medical Record# _____

Age: _____ Date of Birth: _____

Sex: M F (circle)

PHYSICIAN INFORMATION

Primary Care Physician: _____

Specialty: _____

Address: _____

Phone: _____ Fax: _____

Referring Physician: _____

Specialty: _____

Address: _____

Phone: _____ Fax: _____

Name of Person Referring You to the Sleep Center: _____

Would you like your records to go to any other physician? Yes No

Other Physician: _____

Specialty: _____

Address: _____

Phone: _____ Fax: _____

1. **Briefly describe your sleep problem:** _____

At what age did this problem begin? _____

How does this affect your life and daily activities? _____

How serious a problem is this for you on a scale of 1 to 10? (1 is not serious and 10 is very serious) _____

2. **Have you had any previous evaluations (exam or sleep study)?** Yes No

When: _____ Where: _____ Results _____

3. **Have you had any previous treatment?** Yes No

When: _____ Where: _____ What type: (i.e., CP AP) _____

4. Please list any medications (prescribed or otherwise) that you have used to help your sleep problem:

DRUG	AMOUNT	FREQUENCY	HOW LONG?	HOW USEFUL?	PHYSICIAN

CHECK CLINIC SITE: Medical Clinic MDC 33 Ent Clinic MDC 73

SLEEP HABITS

5. If employed, what are your usual working hours?

Start: _____ am / pm

Stop: _____ am / pm

6. Do you ever change work shifts? Never Infrequently Regularly

7. Write in the time you usually go to bed and get up on weekdays.

Go to bed _____ am / pm

Get up _____ am / pm

8. Write in the time you usually go to bed and get up on weekends.

Go to bed _____ am / pm

Get up _____ am / pm

9. Do you have a regular sleep partner? Yes No

10. On the average, how long does it take you to fall asleep? _____ Minutes

11. What do you ordinarily do just prior to going to sleep? (e.g. reading, TV, bath, etc)

Reading TV Bath Exercise Eat

Other: _____

12. On the average, how often do you wake up during the night? _____ Times

13. Do you ever wake up too early in the morning and then are unable to return to sleep? Yes No

14. On the average, how long are you actually asleep at night? _____ hours _____ minutes

15. How do you ordinarily awaken? Spontaneously Alarm Clock Other

16. How difficult is it for you to awaken and get out of bed after sleeping?

Very Difficult Difficult Sometimes Difficult No Problem

17. How long does it take for you to be alert and functioning after sleeping? _____ hours _____ minutes

18. Do you nap or return to bed after arising? Yes No Sometimes

If yes, how many times per day? _____ Average length of nap: _____ hours _____ minutes

19. Are you bothered by sleepiness during the day? Yes No

20. Do you feel you get too much sleep at night? Yes No

21. Do you feel you get too little sleep at night? Yes No

22. Do you usually feel tired during the day? Yes No

If yes, what do you attribute this to? _____

23. Do you find yourself falling asleep when you don't mean to? Yes No

If yes, describe: _____

How long does the sleep episode last? _____ hours _____ minutes

Do you feel rested or refreshed after the sleep episode? Yes No

24. Have you ever suddenly fallen? Yes No

25. Have you ever experienced sudden bodily weakness (jaw, head, shoulders, arms, legs)? Yes No

If you have suddenly fallen or experienced weakness, were you aware of things around you? Yes No

Was the fall or weakness brought on by any particular event or feeling (laughter, fear, sadness, etc.)? Yes No

If so, briefly describe: _____

26. Have you ever experienced muscle weakness or paralysis upon:

Going to sleep? Yes No

Awakening from sleep? Yes No

How often does this occur? _____ Times/Week

27. Have you experienced seeing things or hearing voices that weren't real?

On going to sleep? Yes No

During the night? Yes No

On awakening from sleep? Yes No

During the day? Yes No

28. Have you experienced a feeling like falling or the bed moving?

On going to sleep? Yes No

During the night? Yes No

On awakening from sleep? Yes No

During the day? Yes No

29. Do you have difficulty breathing at night?

If so, briefly describe: _____

How often? _____ Times/Night When did this first occur? _____ (Age)

30. Have you been told you snore when you sleep? Yes No

Does the snoring disturb:

A bed partner (or someone in the same bedroom)? Yes No

Someone in the next room? Yes No

31. Have you been told you stop breathing when you sleep? Yes No

32. Have you ever experienced, upon lying in bed, before sleep, or on awakening from sleep, a restlessness of legs, "nervous legs," a creeping crawling sensation of legs or twitching? Yes No

How often does this occur? _____ times/week

How long does the sensation last? _____ Minutes

Does anything relieve the sensation (e.g. getting out of bed, a massage, medication, etc)? _____

When did you first experience this? _____ (age) Yes No

33. Has anyone ever told you that your arms or legs jerk or twitch while you are asleep? Yes No

If yes, how often during the night does this occur? _____ times/night

How many nights per week does this happen? _____ times/week

At what age did this come to your attention? _____

Does this seem to awaken you from sleep? Yes No

34. Have you ever experienced doing something without being aware at the time of the action? Yes No

If so, briefly describe: _____

How often does this occur? _____ times/week

35. Do you know or do others tell you that you:

Treatment

Talk while apparently asleep? Yes No _____ times/week _____ age started _____

Walk while apparently asleep? Yes No _____ times/week _____ age started _____

Grit teeth while apparently asleep? Yes No _____ times/week _____ age started _____

Wet the bed during sleep? Yes No _____ times/week _____ age started _____

Wake up screaming or seemingly afraid? Yes No _____ times/week _____ age started _____

Have disturbing dreams? Yes No _____ times/week _____ age started _____

Have unusual movements? Yes No _____ times/week _____ age started _____

Awake during the night with headaches? Yes No _____ times/week _____ age started _____

Have erections while asleep (males)? Yes No _____ times/week _____ age started _____

ALLERGIES (Specify drug and reaction)

_____	_____
_____	_____
_____	_____
_____	_____

MEDICATIONS

Do you use any prescribed medications either regularly or occasionally?

Yes No

If so, please list by name below (include over the counter medications, herbal products, supplements, and vitamins):

Name of Medication	Amount	How Often	Reason Used	How Long Used	Prescribing Physician

Give the year of your last physical examination _____

Results of this exam _____

Height: _____ inches Weight: _____ pounds Neck Size: _____ inches

Have you now or ever in the past experienced any health problems or had surgery associated with the below listed areas?

	Yes	Type of Problem	Dates	Physician, Clinic or Hospital
A - mental health				
B - head or nervous system				
C - eyes, ears, nose, mouth, throat				
D - heart, circulation				
E - breathing (lungs)				
F - stomach, digestive				
G - urine, kidney				
H - sexual				
I - bones, joints, arms, legs				
J - diabetes, glands				
K - blood pressure				
L - weight problems				
M - other				

SOCIAL HISTORY (tobacco, caffeine, alcohol, drug use)

Do you currently smoke cigarettes? Yes No How many years? _____ # packs per day _____

Have you used tobacco products like cigars, pipes, or smokeless tobacco? Yes No

How many years? _____ # per day _____

Do you currently consume alcohol? Yes No

How many years? _____ What type? _____ Amount per day _____

On the average, how many alcoholic beverages do you drink on weekdays? _____ Drinks/day

On the average, how many alcoholic beverages do you drink on weekends? _____ Drinks/day

Have you received treatment for substance abuse? Yes No

On average, how much do you drink of the following beverages?

Coffee _____ cups/day

Tea _____ cups/day

Carbonated or other soft drinks _____ bottles/day

OCCUPATIONAL HISTORY

Current job _____ Year started _____

Previous positions _____

FAMILY HISTORY

Marital Status _____ Number of Children _____ Ages _____

Family Member	Age	Living	Deceased	Illnesses*	Cause of Death	List Sleep Problems
Father						
Mother						
Brothers						
Sisters						
Children (indicate sex)						

**Include cancer, diabetes, heart attacks, high blood pressure, strokes, tuberculosis, and other major illnesses.*

REVIEW OF SYSTEMS

Check all responses that apply.

General

	Yes	No
Weight gain/loss	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty falling asleep	<input type="checkbox"/>	<input type="checkbox"/>
Need to cut down alcohol consumption	<input type="checkbox"/>	<input type="checkbox"/>
Fever	<input type="checkbox"/>	<input type="checkbox"/>
Change in appetite	<input type="checkbox"/>	<input type="checkbox"/>

Skin

	Yes	No
Rash, sore, or excessive bruising	<input type="checkbox"/>	<input type="checkbox"/>
Lump or growth on skin	<input type="checkbox"/>	<input type="checkbox"/>

Eyes

	Yes	No
Wear glasses	<input type="checkbox"/>	<input type="checkbox"/>
Decreased vision	<input type="checkbox"/>	<input type="checkbox"/>
Pain in eyes	<input type="checkbox"/>	<input type="checkbox"/>

Ears, Nose, Throat, Mouth

	Yes	No
Difficulty or changes in hearing	<input type="checkbox"/>	<input type="checkbox"/>
Earaches	<input type="checkbox"/>	<input type="checkbox"/>
Discharge from ears	<input type="checkbox"/>	<input type="checkbox"/>
Buzzing or ringing in ears	<input type="checkbox"/>	<input type="checkbox"/>
Frequent sneezing	<input type="checkbox"/>	<input type="checkbox"/>
Nose stuffiness or running	<input type="checkbox"/>	<input type="checkbox"/>
Recurrent sore throat	<input type="checkbox"/>	<input type="checkbox"/>
Persistent hoarseness	<input type="checkbox"/>	<input type="checkbox"/>
Dental problems	<input type="checkbox"/>	<input type="checkbox"/>
Sinus problems	<input type="checkbox"/>	<input type="checkbox"/>
Lymph glands or nodes	<input type="checkbox"/>	<input type="checkbox"/>
Frequent nose bleeds	<input type="checkbox"/>	<input type="checkbox"/>

Genitourinary

	Yes	No
Painful urination	<input type="checkbox"/>	<input type="checkbox"/>
Frequent urination	<input type="checkbox"/>	<input type="checkbox"/>
Blood in urine	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty emptying bladder	<input type="checkbox"/>	<input type="checkbox"/>

Musculoskeletal

	Yes	No
Painful joints	<input type="checkbox"/>	<input type="checkbox"/>
Sore muscles	<input type="checkbox"/>	<input type="checkbox"/>
Back pain	<input type="checkbox"/>	<input type="checkbox"/>
Pain in calves of legs	<input type="checkbox"/>	<input type="checkbox"/>
Weakness in extremities	<input type="checkbox"/>	<input type="checkbox"/>
Numbness in extremities	<input type="checkbox"/>	<input type="checkbox"/>

Neuropsychiatric

	Yes	No
Anxiety	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>
Frequent or severe headaches	<input type="checkbox"/>	<input type="checkbox"/>
Dizziness or faintness	<input type="checkbox"/>	<input type="checkbox"/>
More nervous than average person	<input type="checkbox"/>	<input type="checkbox"/>
Dizziness or faintness	<input type="checkbox"/>	<input type="checkbox"/>

Cardiovascular

	Yes	No
Chest pain	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>
Abnormal swelling in legs/feet	<input type="checkbox"/>	<input type="checkbox"/>
Fatigue or tire easily	<input type="checkbox"/>	<input type="checkbox"/>

Respiratory

	Yes	No
Cough	<input type="checkbox"/>	<input type="checkbox"/>
Blood in sputum	<input type="checkbox"/>	<input type="checkbox"/>
Wheezing	<input type="checkbox"/>	<input type="checkbox"/>

Endocrine

	Yes	No
Excessive thirst or urination	<input type="checkbox"/>	<input type="checkbox"/>
Change in sexual drive/performance	<input type="checkbox"/>	<input type="checkbox"/>
Change in heat or cold tolerance	<input type="checkbox"/>	<input type="checkbox"/>

Gastrointestinal

	Yes	No
Frequent heartburn/indigestion	<input type="checkbox"/>	<input type="checkbox"/>
Nauseas or vomiting	<input type="checkbox"/>	<input type="checkbox"/>
Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>
Constipation	<input type="checkbox"/>	<input type="checkbox"/>
Blood in stool	<input type="checkbox"/>	<input type="checkbox"/>
Ulcers	<input type="checkbox"/>	<input type="checkbox"/>

For Women Only

	Yes	No
Irregular periods	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding between periods	<input type="checkbox"/>	<input type="checkbox"/>
Are you pregnant	<input type="checkbox"/>	<input type="checkbox"/>
Date of last menstrual period	___ / ___ / ___	
Ever have an abnormal Pap smear	<input type="checkbox"/>	<input type="checkbox"/>
Lump or growth on breast	<input type="checkbox"/>	<input type="checkbox"/>

Allergic/Immunologic

	Yes	No
Hayfever	<input type="checkbox"/>	<input type="checkbox"/>
Hives	<input type="checkbox"/>	<input type="checkbox"/>
Immunodeficiency	<input type="checkbox"/>	<input type="checkbox"/>

Hematologic/Lymphatic

	Yes	No
Anemia	<input type="checkbox"/>	<input type="checkbox"/>
Excessive bleeding or bruising	<input type="checkbox"/>	<input type="checkbox"/>
Blood Transfusion	<input type="checkbox"/>	<input type="checkbox"/>

Reviewed by:

_____ MD _____ Date

_____ RN _____ Date

HOSPITAL ANXIETY AND DEPRESSION SCALE

This questionnaire is designed to help your doctor know how you feel. Ignore the numbers printed on the left of the questionnaire. Read each item and underline the reply that comes closest to how you have been feeling in the last week. Don't take too long over your replies; your immediate reaction to each item will probably be more accurate than an exhaustively considered response.

A I feel tense or "wound up"
 3 All of the time
 2 A lot of the time
 1 From time to time, occasionally
 0 Not at all

D I feel as if I am slowed down
 3 Nearly all of the time
 2 Very often
 1 Sometimes
 0 Not at all

D I still enjoy things I used to enjoy
 0 Definitely as much
 1 Not quite so much
 2 Only a little
 3 Hardly at all

A I get a sort of frightened feeling, like "butterflies in the stomach"
 0 Not at all
 1 Occasionally
 2 Quite often
 3 Very often

A I get a sort of frightened feeling as if something awful is about to happen
 3 Very definitely and quite badly
 2 Yes, but not too badly
 1 A little, but it doesn't worry me
 0 Not at all

D I have lost interest in my appearance
 3 Definitely
 2 I don't take as much care as I should
 1 I may not take as much care
 0 I take just as much care as ever

D I can laugh and see the funny side of things
 As much as I always could
 1 Not quite so much now
 2 Definitely not so much now
 3 Not at all

A I feel restless, as though I have to be on the move
 3 Very much indeed
 2 Quite a lot
 1 Not very much
 0 Not at all

A Worrying thoughts go through my mind
 3 A great deal of the time
 2 A lot of the time
 1 From time to time, but not too often
 0 Only occasionally

D I look forward with enjoyment to things
 0 As much as I ever did
 1 Rather less than I used to
 2 Definitely less than I used to
 3 Hardly at all

D I feel cheerful
 3 Not at all
 2 Not often
 1 Sometimes
 0 Most of the time

A I get sudden feelings of panic
 3 Very often indeed
 2 Quite often
 1 Not very often
 0 Not at all

A I can sit at ease and feel relaxed
 0 Definitely
 1 Usually
 2 Not often
 3 Not at all

D I can enjoy a good book, radio or TV program
 0 Often
 1 Sometimes
 2 Not often
 3 Very seldom

A Total: _____

D total: _____

Name: _____

Date: _____

THE EPWORTH SLEEPINESS SCALE

Name: _____

Date: _____

Your Age: _____

Sex (male=M, female=F): _____

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired? This refers to your usual way of life in recent times. Even if you have not done some of these things recently, try to imagine how they would have affected you. Use the following scale to choose the most appropriate number for each situation.

- 0 = would *never* doze
- 1 = *slight* chance of dozing
- 2 = *moderate* chance of dozing
- 3 = *high* chance of dozing

Situation:

Chance of Dosing:

- Sitting and reading
- Watching TV
- Sitting, inactive in a public place
- As a passenger in a car 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 stopped for a few minutes in traffic

Thank you for your cooperation.

Total: _____