PULMONARY & SLEEP ASSOCIATES
HEALTH HISTORY

Patient Name: ______________________________ Today's Date: __________________
Date of Birth: ______________________________

Reason why you came here today: ____
Who sent you here: ____

Brief history of problem (include start date, symptoms, tests performed, meds taken, etc):
____
____
____
____
____

Influenza Vaccination: ________________ Pneumonia Vaccination: _______________
Last Mammography: __________________ Last Colonoscopy: _____________________

Medical History:

__Heart Attack	__Asthma	__High Blood Pressure	__Cancer
__Heart Failure	__Emphysema	__GERD	__Blood Clots
__Irregular Heartbeat	__Chronic Bronchitis	__Ulcers	__Legs
__Sleep Apnea	__Tuberculosis	__Depression	__Lungs
__Stroke(s)	__Diabetes	__Thyroid	__Arthritis
__Allergies	__Insomnia	__ Seizure Disorder	__Other:____

Comments:
____
____

Surgical History:

__Tonsillectomy	__Gallbladder	__Appendix	__Knee
__Hysterectomy	__Hernia	__Sinus	__Hip
__Carotid	__Heart	__Other:__________	

Pediatrics only:

Pregnancy: Full term Preterm Delivery: Complicated Uncomplicated
Hit age-appropriate milestones (crawling, walking, etc.): Yes No
Comments: ____
Other physicians/therapists involved in care: ____________________________________

ALL PATIENTS CONTINUE

Social History:

Marital Status: M S D W Type of Residence: Home/apt Institution Asst. Living

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Date __________

Current/former occupation(s):____
Alcohol use: Yes No Type/quantity/frequency: ___________________________
Illicit drug use: Yes No Type/quantity/frequency: ____________________________
Caffeine use: Yes No Type/quantity/frequency: ____________________________
House pets: Yes No Type(s): ____
Tobacco history: Current Former Never
Type(s): _______________________ Quantity/frequency: ____________________
Quit date: ______________________ Total years used: ______________________
Methods used to quit: ____
Exposed to secondhand smoke: Yes No Total years: ___________________________
Exposed to dust, fumes, chemicals or asbestos: Yes No Total years:_______________
Describe:____

Family History:

	Father	Mother	Sister(s)	Brother(s)	Son(s)	Daughter(s)
Current age	_____	______	_______	________	_____	________
Age of death	_____	______	_______	________	_____	________
Cause of death	_____	______	_______	________	_____	________
Heart disease/attack	_____	______	_______	________	_____	________
Lung disease	_____	______	_______	________	_____	________
Tuberculosis	_____	______	_______	________	_____	________
Cancer (type)	_____	______	_______	________	_____	________
Diabetes	_____	______	_______	________	_____	________
High blood pressure	_____	______	_______	________	_____	________
Alcohol/drug abuse	_____	______	_______	________	_____	________
Sleep apnea	_____	______	_______	________	_____	________
Insomnia	_____	______	_______	________	_____	________

Sleep History:

EPWORTH SLEEPINESS SCALE
How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling 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 work out how they would affect 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.**

__Sitting and reading
__Sitting, inactive in a public place (movie theater, meeting)
__Lying down to rest after noon, circumstances permitting
__Sitting and talking to someone
__Watching television
__As a passenger in a car for an hour, without a break
__In a car, while stopped for a few minutes in traffic
__Sitting quietly after lunch without alcohol

Total: __________

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Date __________

What time do you turn the lights out to go to sleep at night: ________________________
How long does it take you to fall asleep, when you put your mind to it: ______________
How many times do you wake up each night, on average: _________________________
For what reason(s): ____
Do you snore: Yes No Do you wake yourself up snoring: Yes No
Have you been told by others that you stop breathing at night: Yes No
Do you walk in your sleep: Yes No Do you talk in your sleep: Yes No
Do your legs bother you at night: Yes No In what way: _________________________
What time do you get up: __________ On own Alarm Snooze bar __ times
Do you feel refreshed upon awakening: Yes No Are you excessively irritable: Yes No
Do you have morning headaches: Yes No Frequency: __________________________
Is your memory as good as it used to be: Yes No Concentration okay: Yes No
Do you nap during the day: Yes No Frequency: __________ Length: _________
Have you had any accidents (at work or driving) due to sleepiness: Yes No
Describe: ____

Review of Systems:

Lungs
__shortness of breath
__at rest
__with activity
__at night
__cough
__dry
__productive
color: _______
__wheezing
__bloody sputum
__difficulty breathing while lying down

Constitutional
__fevers/chills
__night sweats
__weight gain
__weight loss

Neurologic
__passing out/fainting
__seizures
__strokes
__numbness/tingling
__tremors/shaking

ENT
__cataracts
__glaucoma
__glasses
__hearing loss
__runny nose
__hayfever
__nasal congestion
__drainage in throat
__nosebleeds

Neck
__swollen glands
__blocked arteries
__enlarged thyroid
__thyroid nodules

Gastrointestinal
__abdominal pains
__nausea/vomiting
__hemorrrhoids
__red stools
__black stools
__indigestion
__heartburn/reflux
__difficulty swallowing

Cardiac
__chest pains
__chest pressure
__irregular heartbeat
__palpitations
__ankle swelling

Genitourinary
__pain with urination
__blood in urine
__decreased urine stream
__incontinence

Skin
__rashes
__unusual bruising
__suspicious lesions
__cyanosis (turning blue)
__jaundice (turning yellow)

Musculoskeletal
__weakness
__arthritis
__use of assistive device (walker, cane, etc.)

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Date __________