

DATE:		DOB:	
LAST NAME:	FIRST NAME:	MIDDLE INITIAL:	
REASON FOR VISIT:			
PRIMARY CARE PHYSICIAN:	HEIGHT:	WEIGHT:	BP:
PREFERRED PHARMACY AND LOCATION:	PULSE:		
The Above Items Area For Office Use Only			

**SOCIAL HISTORY – ENVIRONMENTAL/BEHAVIORAL RISK FACTORS**

			COMMENTS
TOBACCO USE:	Current	Former	Never
ALCOHOL USE:	Current	Non-Drinker	
CAFFEINE USE:	Uses	No use	
SEXUALLY ACTIVE:	Yes	No	
DATE OF LAST MAMMOGRAM :			
DATE OF LAST FLU SHOT:			
DATE OF LAST PNEUMOVAX SHOT:			

**FAMILY HISTORY – GENETIC FACTORS: THIS INFORMATION IS ABOUT YOUR FAMILY**

			IF YES,WHO?	IF YES,WHO?	IF YES,WHO?			
<b>CARDIOVASCULAR</b>			<b>HEMATOLOGIC</b>		<b>NEUROLOGIC</b>			
Coronary Artery Disease	Y	N	Bleeding Disorder	Y	N	Alzheimer's Disease	Y	N
Heart Disease	Y	N	Hematologic Disorder	Y	N	Dementia	Y	N
Hyperlipidemia	Y	N	Hemophilia	Y	N	Migraine	Y	N
Hypertension	Y	N	Sickle Cell Anemia	Y	N	Stroke	Y	N
Ischemic Heart Disease	Y	N	<b>MENTAL HEALTH/ SUBSTANCE ABUSE</b>		<b>ONCOLOGIC</b>			
Sudden Death	Y	N	Alcoholism	Y	N	Breast Cancer	Y	N
<b>ENDOCRINE/ METABOLIC</b>			Attention Deficit Disorder	Y	N	Colorectal Cancer	Y	N
Diabetes Mellitus	Y	N	Bipolar Disorder	Y	N	Endometrial Cancer	Y	N
Thyroid Disorder	Y	N	Depressive Disorder	Y	N	Lung Cancer	Y	N
<b>EYES, EARS, NOSE &amp; THROAT</b>			Mental Disorder	Y	N	Melanoma	Y	N
Glaucoma	Y	N	Schizophrenia	Y	N	Ovarian Cancer	Y	N
Hearing Loss	Y	N	Smoking Tobacco	Y	N	Prostate Cancer	Y	N
Visual Loss	Y	N	<b>MUSCULOSKELETAL</b>		Skin Cancer	Y	N	
<b>GENETIC/BIRTH</b>			Osteoarthritis	Y	N	Stomach Cancer	Y	N
Birth Defects	Y	N	Osteoporosis	Y	N	Cancer – Other	Y	N
<b>GENITOURINARY</b>			Other Inflammatory Connective D/O	Y	N	<b>RESPIRATORY</b>		
Endometriosis	Y	N	Rheumatoid Arthritis	Y	N	Asthma	Y	N
Polycystic Kidney Disease	Y	N	Rheumatologic Disorder	Y	N	Pulmonary Embolism	Y	N
Polycystic Ovary Disease	Y	N	Systemic Lupus	Y	N	Respiratory Disorder	Y	N
Toxemia Of Pregnancy	Y	N				Tuberculosis	Y	N



<b>Constitutional</b>		
Fatigue	N	Y
Weight Loss	N	Y
Fever	N	Y
<b>Eyes</b>		
Diplopia (double vision)	N	Y
Blurred Vision	N	Y
Eye Pain	N	Y
<b>Ears (Left And Right)</b>		
Hearing Loss	N	Y
<b>Nose, Throat</b>		
Nasal Congestion	N	Y
Sore Throat	N	Y
<b>Respiratory</b>		
Dyspnea (shortness of breath)	N	Y
Cough	N	Y
Wheezing	N	Y
<b>Cardiovascular</b>		
Chest Pain	N	Y
Edema	N	Y
Claudication (leg pain w/walking)	N	Y
<b>Breasts</b>		
Breast Tenderness	N	Y
<b>Gastrointestinal</b>		
Abdominal Pain	N	Y
Nausea	N	Y
Blood in stool	N	Y
<b>Hematologic/Lymphatic</b>		
Swollen Glands	N	Y
Bruises Easily	N	Y
Bleeds Easily	N	Y
<b>Musculoskeletal</b>		
Neck Pain	N	Y
Back Pain	N	Y
Muscle Pain	N	Y
<b>Skin</b>		
Skin Rash	N	Y
Skin Lesion	N	Y
Pruritus (itching)	N	Y
<b>Neurologic</b>		
Headache	N	Y
Numbness	N	Y
Paresthesia (tingling)	N	Y

<b>Psychiatric</b>		
Difficulty Sleeping	N	Y
Feeling Anxious	N	Y
Feeling Depressed	N	Y
<b>Endocrine</b>		
Intolerant of cold	N	Y
Intolerant of heat	N	Y
<b>Allergic, Immunologic</b>		
Susceptibility To Infections	N	Y
Impaired Wound Healing	N	Y
<b>Genitourinary, Female</b>		
Dysuria (painful urination)	N	Y
Hematuria (blood in urine)	N	Y
Nocturia (frequent night time urination)	N	Y
<b>Genitourinary, Male</b>		
Dysuria (painful urination)	N	Y
Hematuria (blood in urine)	N	Y
Nocturia (frequent night time urination)	N	Y
<b>Blood Disorders/Problems</b>		
Family history of bleeding disorders/problems	N	Y
Personal history of bleeding disorders/problems	N	Y
<b>Anesthesia Problems</b>		
Family history of problems	N	Y
Personal history of problems	N	Y
<b>Malignant hyperthermia</b>		
Family history of problems	N	Y
Personal history of problems	N	Y

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Today's Date: \_\_\_\_\_

**ADULT NEW PATIENT QUESTIONNAIRE**

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Doctors caring for you (family doctor, specialists, psychologist, etc.)

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**Main Complaint**

What is your main sleep or alertness complaint? How long has it occurred?

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If you have ever had a sleep study, please indicate when and where.

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**Daytime Sleepiness**

How would you rate your usual daily sleepiness?	Chance Of Dozing			
	Never	Occasionally	Often	Always
Situation:				
Sitting and reading	0	1	2	3
Watching TV	0	1	2	3
Sitting inactive in a public place (e.g theatre, meeting)	0	1	2	3
As a passenger in a car for an hour without a break	0	1	2	3
Lying down to rest in the afternoon when circumstances permit	0	1	2	3
Sitting and talking to someone	0	1	2	3
Sitting quietly after a lunch without alcohol	0	1	2	3
In a car, while stopped for a few minutes in traffic	0	1	2	3

What is the sleepest time of day? \_\_\_\_\_

If you are excessively sleepy or fatigued, how long has this been going on? Do you have any ideas as to why this is happening?

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## Sleep Routine

When you go to bed on weekdays? \_\_\_\_\_ Weekends? \_\_\_\_\_

What time do you get up on weekdays? \_\_\_\_\_ Weekends? \_\_\_\_\_

How long does it take to fall asleep? \_\_\_\_\_ Do you have trouble falling asleep? \_\_\_\_\_

How often do you awaken at night? \_\_\_\_\_ What causes it? \_\_\_\_\_

How long are you awake? \_\_\_\_\_ How often do you urinate at night? \_\_\_\_\_

How many hours of sleep do you get in a typical night? \_\_\_\_\_

Do you usually sleep alone?  Yes  No

How do you feel when you wake up? \_\_\_\_\_

Do your hands or arms tingle, hurt or go numb at night?  Yes  No

Do your legs feel like you need to frequently move, rub or stretch them at night?  Yes  No

## Sleep Events

While asleep do you:	Never	Occasionally	Often	Always
Have heartburn or chest pain?	1	2	3	4
Grind teeth?	1	2	3	4
Drooling?	1	2	3	4
Have jerks or twitches?	1	2	3	4
Have nightmares?	1	2	3	4
Sleep in an unusual position?	1	2	3	4
Cough?	1	2	3	4
Wake up with headaches?	1	2	3	4
Wake up with a sore throat?	1	2	3	4
Wake up with a dry mouth?	1	2	3	4
Toss and turn restlessly?	1	2	3	4
Gasping or choke?	1	2	3	4
Stop breathing?	1	2	3	4

ADULT NEW PATIENT QUESTIONNAIRE

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Snoring Scale (circle one)

- 5 – Snoring is continuous and so loud, it can be heard despite being in a different room and using earplugs: “heroic snoring”
- 4 – Snoring is continuous and so loud, I must go to another room or use earplugs in order to sleep: “persistent terrible snoring”
- 3 – Snoring I frequently loud enough so that I awaken and nudge him/her so he/she will turn over and stop snoring “persistent loud snoring”
- 2 – Snoring occurs daily, but is a soft snore
- 1 – Snoring is present, but does not disturb me or bother my sleep: “occasional soft snore”
- 0 – No snoring

**Parasomnias**

- Do you sometimes awaken with the feeling you are completely paralyzed?  Yes  No
- Do you ever hallucinate sights or sound while falling asleep as if your dreams are beginning before you are fully asleep?  Yes  No \_\_\_\_\_
- Do you sleep walk, talk or moan?  Yes  No \_\_\_\_\_
- Do you perform unusual behaviors during sleep?  Yes  No \_\_\_\_\_
- Do you have brief attacks of muscle weakness?  Yes  No \_\_\_\_\_

**Sleep Hygiene**

- Do you drink beverages with caffeine (coffee, tea, cola, Mountain Dew, etc.) or take caffeine pills?  
 Yes  No If so, how much, what time of day? \_\_\_\_\_
- How much chocolate do you eat or drink on an average day? \_\_\_\_\_
- Do you exercise routinely?  Yes  No If so, what time of day? \_\_\_\_\_
- Do you do anything stressful or anxiety provoking before going to bed?  Yes  No If so, please describe: \_\_\_\_\_
- Is there anything in your bedroom that could be disturbing your sleep?  Yes  No (room temperature, noise, pets, etc.) \_\_\_\_\_
- Do you nap more than once a week?  Yes  No If so, please describe: \_\_\_\_\_

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Do you smoke or otherwise use tobacco?  Yes  No If so, how much a day? \_\_\_\_\_

How much alcohol do you drink per week? \_\_\_\_\_

## Review of Systems

Do you have any problems relating to?

- Breathing while awake
- Frequent headaches
- Heartburn
- Depression
- Seizures
- Long term pain condition
- Intolerance to cold or heat
- Loss of sex drive or performance
- Difficulty with concentration or memory
- Irritability or mood swings
- Weight gain or loss over the last few years
- Leg or ankle swelling
- Do you have dentures

## Social History

Occupation \_\_\_\_\_

Who lives at home \_\_\_\_\_

Marital Status \_\_\_\_\_

Number of children \_\_\_\_\_

## Additional Information

Is there anything else that you feel may be important for the physician to know about your sleep and alertness problems or your health?  Yes  No

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