Pulmonary Associates of LVPG
A practice of Lehigh Valley Physician Group

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PATIENT INFO SLEEP VISIT

Today's Date _____

Name:_____ Date of Birth _____

Address:_____ Phone_____

Race: ❑ Black/African American ❑ American Indian/Alaskan Native/Eskimo ❑ Multi-Racial ❑ Pacific Islander
❑ Asian ❑ White ❑ Unavailable ❑ Refused ❑ Unknown: patient unsure of race

Ethnicity: ❑ Hispanic/Latino ❑ Not Hispanic/Latino ❑ Unavailable ❑ Refused

Place of Employment: _____

Occupation:_____ Phone_____

Marital Status: ❑ S ❑ M ❑ W ❑ D ❑ Sep Sex: ❑ M ❑ F SS# _____

Spouse Name:_____ DOB _____ SS#_____

Referring Physician Name: _____

Address:_____ Phone_____

Pharmacy Name: _____

Address:_____ Phone_____

Do you have an Advance Directive (Living Will or Durable Power of Attorney)? ❑ Yes ❑ No

If no, would you like information about Advance Directives? ❑ Yes ❑ No

A. Describe your sleep/wake complaint: (What actually brings you here?)

_____

1. Do you have trouble falling asleep? ❑ Yes ❑ No
2. Do you have trouble staying asleep? ❑ Yes ❑ No
3. Do you have abnormal movements/behaviors during sleep? ❑ Yes ❑ No

B. The following questions are about *your* typical schedule:

1. What time do you usually go to bed? _____ ❑ AM ❑ PM
2. What time do you usually get out of bed? _____ ❑ AM ❑ PM
3. How long does it take you to fall asleep?_____
4. How many times are you awakened from sleep each night? _____
5. Once awake, how long does it take you to go back to sleep?_____
6. How many hours of sleep do you estimate you get per night? _____
7. Are you a shift worker? ❑ Yes ❑ No
8. What shift do you or did you work?_____

C. The following are questions about how sleepy you feel during your awake time. How likely are you to doze off or fall asleep in the following situations? This refers to your usual way of life in recent times.

Please 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 DOZING**
Sitting and reading	_____
Watching TV	_____
Sitting, inactive in a public place (e.g., movie, 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	_____

1. Do you feel refreshed upon awakening? ❑ Yes ❑ No
2. How long have you been sleepy? _____
3. Is your daytime sleepiness ❑ mild ❑ moderate ❑ severe
4. Are you sleepy at work? ❑ Yes ❑ No
5. Do you fall asleep at work? ❑ Yes ❑ No
6. Do you fall asleep when driving your car? ❑ Yes ❑ No
7. How many times have you fallen asleep while driving? _____
8. After how many minutes of driving do you become sleepy? _____
9. Have you had any car accidents due to sleepiness? ❑ Yes ❑ No
10. Do you take naps during the day? ❑ Yes ❑ No
11. Do you feel refreshed after a nap? ❑ Yes ❑ No
12. Is your daytime performance in work or recreation less efficient than you would like it to be? ❑ Yes ❑ No
13. Are you having problems with your memory? ❑ Yes ❑ No
14. Do you have trouble concentrating during the day? ❑ Yes ❑ No
15. Do you have uncontrollable urges to fall asleep during the day? ❑ Yes ❑ No
16. Do you have hallucinations or dream-like mental images when you are falling asleep? ❑ Yes ❑ No
17. Do you feel paralyzed when falling asleep? ❑ Yes ❑ No
18. Do you have attacks of sudden physical weakness or paralysis during the day, when laughing, angry or in other emotional situations? ❑ Yes ❑ No

D. The following questions concern symptoms and behaviors related to sleep:

1. Have you ever been told that you snore loudly? ❑ Yes ❑ No
2. Does your bed partner say that you stop breathing when you are sleeping? ❑ Yes ❑ No
3. Do you sometimes wake you feeling like you are choking or gasping for breath? ❑ Yes ❑ No
4. How many mornings per week do you awaken with a headache? _____
5. Is your mouth dry upon awakening in the morning? ❑ Yes ❑ No
6. Do you have “restless legs” when you lie down in bed before you fall asleep? ❑ Yes ❑ No
7. Have you ever been told your legs twitch during the night? ❑ Yes ❑ No
8. Do you walk in your sleep? ❑ Yes ❑ No
9. Do you talk in your sleep? ❑ Yes ❑ No
10. Do you grind your teeth during sleep? ❑ Yes ❑ No
11. Do you wet the bed during sleep? ❑ Yes ❑ No
12. Do you have frightening dreams or nightmares? ❑ Yes ❑ No

E. The following questions deal with medical problems that can affect sleep:

1. Do you have arthritis, joint pain or back pain? ❑ Yes ❑ No
2. Have you ever had a convulsion (e.g. fit, epilepsy, seizure)? ❑ Yes ❑ No
3. How much weight have you gained in the past year? _____
4. What is your neck size? _____
5. Do you have nasal stuffiness? ❑ Yes ❑ No
6. Have you ever suffered from a head injury? ❑ Yes ❑ No
7. Do you feel depressed, sad or "blue" during the day? ❑ Yes ❑ No
8. Would you classify your depression as: ❑ mild ❑ moderate ❑ severe
9. Do you frequently feel anxious or worried during the day? ❑ Yes ❑ No
10. If you are a woman, are you pregnant? ❑ Yes ❑ No
11. If you are a woman, are you past menopause (change of life) or are you having menopausal symptoms now? ❑ Yes ❑ No
12. Are your sleep complaints cyclical (occurring only in the evening, every 10 days, when you sleep away from home, etc)? ❑ Yes ❑ No
13. Do you have palpitations during the night? ❑ Yes ❑ No
14. How many times per week do you wake up from sleep and eat something other than water before going back to sleep? _____
15. Are you awake at night because of nausea/vomiting? ❑ Yes ❑ No
16. Have you ever been told that you have Fibromyalgia? ❑ Yes ❑ No

F. Medication/Drug History:

Please list your current prescription medications (use a separate sheet if more space is needed)

Name of Medication	Dosage	Times per day	Reason	Length used	Prescribing Physician

1. Which non-prescription drugs do you use? _____

_____

G. Alcohol, Tobacco and Caffeine History:

1. How much alcohol (beer, wine, liquor) do you drink each week? _____ ounces _____drinks
2. How much tobacco do you smoke per day? _____ packs _____ cigars _____pipes
3. How many of the following beverages do you consume?

	# Per day	# After 6:00 pm
Caffeinated Beverages		
Coffee, regular/decaf		
Tea, regular/decaf		
Soft drinks (Pepsi, Coke, etc.)		

H. Allergies

Drugs (ex. Penicillin, aspirin, sulfa, etc): Please list drugs and reaction.

_____

I. Medical History:

What medical conditions are you presently being treated for?_____

_____

J. Family History: *(Please check the appropriate box)*

	Father	**Mother**	**Son/Daughter**	**Sibling**	**Sibling**
Living	❑	❑	❑	❑	❑
Deceased	❑	❑	❑	❑	❑
Age	_____	_____	_____	_____	_____
Snoring	❑	❑	❑	❑	❑
Sleep Apnea	❑	❑	❑	❑	❑
High Blood Pressure	❑	❑	❑	❑	❑
Heart Attack	❑	❑	❑	❑	❑
Angina	❑	❑	❑	❑	❑
Stroke	❑	❑	❑	❑	❑
Diabetes	❑	❑	❑	❑	❑
Narcolepsy	❑	❑	❑	❑	❑

K. ROS *(Review of systems):* Do you have any of the following? **(Check all that apply)**

General	❑ Fever	❑ Loss of appetite	❑ Night sweats	❑ Weight loss
	❑ Sweats	❑ Chills	❑ Weight gain	❑ None
Eyes	❑ Cataracts	❑ Glaucoma	❑ Double vision	
	❑ Dry eyes	❑ Blindness	❑ None	
Ear, Nose and Throat	❑ Nose bleeds	❑ Snoring	❑ Mouth sores	❑ Change in voice
	❑ Earaches	❑ Sinus condition	❑ Nasal polyps	❑ None
Heart Disease	❑ Angina	❑ Pain in the leg walking	❑ Palpitations	❑ Swelling of ankles
	❑ Chest pain	❑ Bad veins in your legs	❑ Phlebitis	❑ None
Gastrointestinal	❑ Trouble swallowing	❑ Constipation	❑ Black bowel movement	
	❑ Nausea or vomiting	❑ Diarrhea	❑ Blood in bowel movement	
	❑ Heartburn	❑ Ulcer	❑ Food sticks in throat with swallowing	
	❑ Pain in abdomen	❑ None		
Genitourinary	❑ Kidney stones	❑ Blood in urine	❑ Frequent urination	
	❑ Burning on urination	❑ Trouble starting stream	❑ None	
Musculoskeletal	❑ Arthritis (joint pain)	❑ Swelling in joint	❑ Chronic back pain	
	❑ Collapsed vertebra	❑ Curvature of the spine	❑ None	
Skin	❑ Rashes: describe _____		❑ None	
Neurological	❑ Seizures	❑ Migraines	❑ Dizziness	
	❑ Fainting	❑ Weakness/Numbness	❑ None	
Psychiatric	❑ Depression	❑ Anxiety	❑ None	
Endocrine	❑ Low blood sugar	❑ High blood sugar	❑ Thyroid condition	❑ None
Hematologic/ Lymphatic	❑ Anemia	❑ Bleeding tendency	❑ Hemophilia	❑ None
	❑ Use aspirin often	❑ Swollen glands	❑ Blood clots	
Allergic/ Immunologic	❑ Hay fever	❑ Allergy injections	❑ None	

If you have any other conditions/symptoms, please list: _____

_____