NORTHWEST PULMONARY AND SLEEP MEDICINE NEW PATIENT FORM

NAME:____ Date of Birth:________________

Who may we thank for referring you to our office? ____
Who is your primary care physician?____

What is the reason of today's visit/Chief complaint: (list in order of importance)
____
____

HISTORY OF THE PRESENT ILLNESS
Do you have the following symptoms: (please check the box if any and circle the answers)
□ Cough: For how long ________________________ Dry Productive Wet
What triggers the cough:
Dust Fumes Smoke Exercise Laugh Other ___________

Any particular timing of the cough? Morning Night Other__________

□ Sputum (phlegm):
How many times a day______________________, color ______________,

□ Coughing up blood:
How long______________ how many times a day________________ how much _________________

□ Shortness of breath:
at rest with activities how long you have been experiencing it______________
how far can you walk on the level before getting out of breath _________________________________
what other activities makes you out of breath____

□ Wheezing: for how long __________________ any timing____________________________________
any position____________________ any trigger________________________

□ Chest pain: For how long _________________ the location of the pain ________________________
quality_____________ any timing _____________ any trigger __________ what relieves it__________

□ Do you have diagnosed sleep apnea:_________________ since when _____________________________
□ Are you on CPAP/BIPAP/ or other type of nighttime breathing device:___________________________
since when_________________________________

Oxygen therapy:
• Are you on oxygen?________ How much?_________________ When?_________________

Neck Size
• What is your neck size?________ (if unknown, we can measure it for you)

EPWORTH SLEEPINESS SCALE

In contrast to just feeling tired, how likely are you to doze off or fall asleep in the following situations? 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)

	0	**1**	**2**	**3**
Sitting and Reading	☐	☐	☐	☐
Watching Television	☐	☐	☐	☐
Sitting inactively in a public place (theatre, meeting)	☐	☐	☐	☐
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 stopping for a few minutes in traffic	☐	☐	☐	☐

Total score ☐

Berlin Sleep Questionnaire

Category I:

Do you snore? ○ Yes ○ No ○ Don't Know

How often do you snore?

○ Nearly every day ○ 3-4 times a week ○ 1-2 times a week

Your snoring loudness

○ Can be heard in adjacent room ○ Louder than talking

○ Loudness bothers others ○ Louder than breathing

Has anyone noticed that you quit breathing during sleep?

○ Yes ○ No

How often? ○ Every day ○ 3-4 times a week ○ -2 times a week

Category II:

How often do you feel tired/fatigued after you sleep?

○ Every day ○ 3-4 times a week ○ 1-2 times a week

How often do you feel tired/fatigued?

○ Every day ○ 3-4 times a week ○ 1-2 times a week

Did you ever get sleepy/doze while driving?

○ Yes ○ No

How many times?

○ Every day ○ 3-4 times a week ○ 1-2 times a week

Category III:

Do you have high blood pressure? ○ Yes ○ No

Are you overweight? ○ Yes ○ No

Vaccines:

- Do you receive yearly Flu shots?________ Your last pneumonia shot?____________________

Past Medical History:

Do you have or have you had any of the following lung problems (please check):

□ COPD (Emphysema, Chronic bronchitis) □ Lung cancer □ lung nodule
□ Asthma □ Cystic fibrosis □ Tuberculosis □ Pneumonia
□ Sarcoidosis □ Lung fibrosis □ Fungus in the lung □ Asbestos lung
□ Recurrent bronchitis □ Pleural effusion □ Blood clots in lungs □ Sleep apnea
□ Insomnia

Other past medical history:

Do you have or have you had any of the following health problems (please check):

□ High blood pressure □ Lupus □ Cancer □ Diabetes
□ High cholesterol □ Scleroderma □ Liver disease □ Sinus disease
□ Heart disease □ Acid reflux (GERD) □ Kidney disease □ Blood clots in legs
□ Stroke □ Irregular heart beat □ Environmental Allergies
□ Narcolepsy □ Depression □ Anxiety
□ Any other health condition____

Have you had any surgery?

□ Lung surgery: , year:_______ □ Chest injury : , year:_______ □ Heart surgery: , year:_______
□ Other surgery: , year:____

Medication list: (including over the counter meds, inhalers and nebulizers):

List all your medications and the doses in the provided space or attach a copy of your list

____
____
____
____
____
____
____
____
____
____
____

Allergies:

- Medication allergies (please indicate the reaction you had to these medications):

____
____

- Food, plants and animals allergy (please indicate the reaction)

____

Social history:
Tobacco history: Chew or Smoke? _________ If yes, how packs per day? _____________________
For how many years?________________Did you quit? ________ When? _________________
Second hand Smoke?________________
Alcohol history: Current:__________________________ Past:_____________________________
Street Drugs: Current or past _______________________
Pets or animals:____
Residence: ever lived on a farm? ____________ Any exposure to molds or mildews?____________
Travel history:___________________________ Overseas: _________________________________
Occupational history: (where, how long and type of work, and type of exposures)
____
____

Family history: (please check the box and indicate which relative)

□ Asthma_____________ □ Lung cancer____________ □ Cystic fibrosis______________
□ Lung fibrosis_________ □ Other cancers__________ □ Heart disease_______________
□ Emphysema_________ □ Lupus_________________ □ Sleep apnea ________________

Review of the systems: (please circle if you have any of the following)

- Appetite: good, fair, poor
- Weight: stable, lost, gained. How much________ over how long_______ fever chills night sweats
- ENT: nasal stuffiness runny nose post nasal drainage sinus headache
recurrent sinus infections sore throat red eyes dry eyes or mouth
- Cardiac: chest pain ankle swelling waking up short of breath fluttering
short of breath if lay flat fainting
- GI: heart burn swallowing difficulty strangling with food or drinks nausea vomiting
diarrhea blood in stool abdominal pain
- Sleep: tired during day sleepy during day difficulty fall asleep restless sleep
non-refreshing sleep snoring quit breathing restless legs leg jerking
sleep hallucinations drop attacks sleep paralysis
- Neuro: headache muscle weakness dizziness, seizures blurred vision double vision
shakiness numbness stroke polio post polio ALS
- Circulation: poor circulation cold hands varicose veins
- Musculoskeletal: stiff or painful joints swollen joints bony pain muscle
- Psychological: anxiety depression panic attacks

Other Previous Tests: (please indicate if you had any of these tests, when and where)
□ Lung function (breathing tests) □ Recent hospitalization □ Chest x ray □ CT scan of the chest
□ Sleep studies (baseline, CPAP, home sleep test)
Where:____
____

In your own words, please tell us any other pulmonary or sleep concerns you are having:
____
____
____
____