General Information

Name: _____DOB: _____Age: _____

Address: _____City/State/Zip:_____

Preferred Phone #: _____Alternate Phone #:_____

Who referred you to us? ☐ Self-Referral ☐ Physician (Name:_____)

Please describe the problem you are having that prompted this referral

History of Present Illness

1) Do you have Cough? ☐ Yes ☐ No *If No, then please skip to question (2)*

How long have you had cough?

How severe is it?

What aggravates your cough: ☐ Pets/molds/pollens/dust mites/roaches ☐ Change in weather ☐ Other

2) Do you have Wheezing? ☐ Yes ☐ No *If No, then please skip to question (3)*

How long have you had wheezing?

How severe is it?

What aggravates your cough: ☐ Pets/molds/pollens/dust mites/roaches ☐ Change in weather ☐ Other

3) Do you have Shortness of breath? ☐ Yes ☐ No *If No, then please skip to question (4)*

How long have you had shortness of breath?

How severe is it?

What aggravates your shortness of breath?

4) Do you have Difficulty sleeping at night/Feeling sleepy during day? ☐ Yes ☐ No *If No, then please skip to question (5)*

How long have you had this problem?

How severe is it?

Has anyone said that you ☐ Snore ☐ Quit breathing in sleep

Has anything relieved your sleep problem?

5) Check if you have any of the following: ☐ Post Nasal Drip ☐ Seasonal allergies/Sinusitis ☐ Acid Reflux ☐ Coughing up blood

6) Check if you use any of the following? ☐ Oxygen ☐ Nebulizer machine ☐ CPAP/BiPAP machine

7) Have you ever had any of the following? ☐ Skin test for Tuberculosis ☐ Contact with someone with Tuberculosis

8) Check if you have you ever had ☐ Chest X-Ray ☐ CT chest ☐ PFT (Breathing Test) ☐ Heart ECHO ☐ Sleep study

List the medications you are allergic to. Write "None" if you are not allergic to any medications.

List the medications you are taking. Include dosages if known. Write "None" if you don't take any medications.

List major hospitalizations & major surgeries you have had

Check if you have any of the following symptoms or signs

☐ Weight Loss - recent	☐ Hoarse Voice	☐ Skin Rash	☐ Anxiety/Depression
☐ Loss of Appetite	☐ Chest Pain	☐ Skin lumps	☐ Heat/Cold Intolerance
☐ Glaucoma	☐ Abdominal Pain	☐ Headaches	☐ Easy Bleeding
☐ Nasal/Sinus congestion	☐ Kidney Stones	☐ Joint Pain	☐ Enlarged Lymph Node
☐ Other		☐ None other than what is checked above	

Check if you have/had any of the following medical conditions

☐ Asthma	☐ Diabetes	☐ Seizures	☐ HIV/AIDS
☐ Emphysema/Bronchitis	☐ High Blood Pressure	☐ Stroke	☐ Hypothyroidism
☐ Blood Clot in Lungs or Legs	☐ Heart Attack	☐ Cancer (Type)	
☐ Other		☐ None other than what is checked above	

Social History

- Do you smoke? ☐ Yes ☐ No If yes, how many packs a day_____& for how many years_____
- If no, then did you smoke in past? ☐ Yes ☐ No If yes, how much_____& when did you quit_____
- Do you have addiction to any of the following? ☐ Alcohol ☐ Illicit drugs
- If female, are you pregnant? ☐ Yes ☐ No
- Do you have any of these pets: ☐ Cat ☐ Dog ☐ Birds ☐ Other
- Did you work around Asbestos? ☐ Yes ☐ No
- Are you ☐ Married ☐ Divorced ☐ Widow(er) ☐ Separated ☐ Never Married
- Do you have children? ☐ Yes ☐ No Do you have siblings? ☐ Yes ☐ No Are your parents alive? ☐ Yes ☐ No

Check if you know a blood relative with any of the following medical conditions

☐ Allergy ☐ Asthma ☐ Sarcoidosis ☐ Insomnia ☐ Narcolepsy ☐ Cancer (Type_____)

☐ Other _____☐ None other than what is checked

How likely are you to doze off in these situations? Use following scale: 0 = Never, 1 = Slight chance, 2 = Moderate, 3 = High

SITUATION	Chance of Dozing	SITUATION	Chance of Dozing
Sitting and reading		Lying down to rest in the afternoon when circumstances permit	
Watching television		Sitting inactive in a public place, (theater, meeting, etc.)	
Sitting quietly after lunch without alcohol		In a car, while stopped, for a few minutes in traffic	
Sitting and talking to someone		As a passenger in a car for an hour without a break	

If you have a sleep related problem, please fill this section also

What time do you go to bed usually and how long does it take for you to fall asleep usually?		
Do you take alcohol or sleeping pill to be able to fall asleep?	☐Yes	☐No
While drifting into sleep, do you dream or feel you cannot move or see/hear things that are not real?	☐Yes	☐No
Have you been told that you toss and turn to an extreme amount?	☐Yes	☐No
Do you wake up at night gasping for air?	☐Yes	☐No
Do you act out in your dreams?	☐Yes	☐No
How many times do you wake up during the night and how long are you awake each time?		
Have you been told that you talk or scream or grind your teeth in your sleep?	☐Yes	☐No
Do you wake up because of heartburn or because of palpitations or because of aches and pains?	☐Yes	☐No
What time do you finally wake up in the morning usually and do you feel rested on waking up?		
Do you take naps during the daytime?	☐Yes	☐No
Do you dream during your naps?	☐Yes	☐No
After naps, do you feel refreshed?	☐Yes	☐No
Have you ever felt a sudden weakness in your body on getting angry, sad or while laughing?	☐Yes	☐No
Do you get urges of sleep and you just cannot stay awake?	☐Yes	☐No
Have you ever fallen asleep while driving a car?	☐Yes	☐No
Do you take caffeine tablets to keep awake?	☐Yes	☐No
How many caffienated drinks (coffee, tea, sodas) do you take during the day usually?		
Do you have a shift work job?	☐Yes	☐No
Do you get a feeling of restlessness in your legs particularly in the evening?	☐Yes	☐No
Have you ever had any surgery for snoring?	☐Yes	☐No
Have you ever had trauma to head?	☐Yes	☐No