

4. List any over the counter or alternative medications you frequently use:

_____	_____
_____	_____
_____	_____

5. List any major medical illnesses you have had (e.g. heart or lung problems, ulcers, acid reflux, strokes, high blood pressure, diabetes, congestive heart failure, cancer, thyroid, depression, anxiety, heart rhythm problems, anemia, asthma, emphysema, COPD, sleep apnea):

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Family History

- List any medical problems or cause of death of your immediate family (blood relatives):

<u>Relative</u>	<u>Medical Problems</u>
_____	_____
_____	_____
_____	_____
_____	_____

Social History

1. What is your present **occupation** _____
2. What **other occupations** have you had _____
3. Yes No Have you had any risk factors for **AIDS/HIV** (blood transfusions, IV drugs, sex with someone with AIDS, hemophilia, homosexual) _____
4. Yes No Do you or have you used illicit street **drugs**? If yes, what type: _____
5. **Marital status** Single Married Divorced Widowed _____
6. Yes No Any **children** if yes, how many _____
7. Yes No Recent **travel** outside of the Midwest over the past year? If yes, where: _____
8. Yes No Exposure to **Tuberculosis**? If yes, to whom _____
9. Yes No Have you had PPD or **Tuberculosis** skin test? Result _____
10. Yes No Have you *ever* **smoked**? Cigar Cigarettes Pipe Chewing Tobacco
How many packs per day *at the most* _____
How many years *at the most* _____
When did you quit _____
11. Yes No Have you been exposed to significant **second hand smoke**
By whom _____
12. Yes No Have you had significant exposure to **birds**, chickens, or bird droppings _____

13. Yes No Have you had significant **occupational exposure** to dust, fumes, chemicals, asbestos, silica, radon, radiation? _____
14. What type of **pets** do you have _____
15. How many **caffeinated beverages** do you drink in a day _____
16. How much **alcohol** do you consume (beer, wine, liquor) _____
17. Yes No Have you ever been an **alcoholic** in the past?

Review of Systems

Have you recently had any of the following? Circle Yes or No. If unsure, leave blank.

Cardiopulmonary

- Yes No Severe shortness of breath
- Yes No Chest pain if yes, please describe _____
- Yes No Cough if yes, please describe _____
- Yes No Phlegm/Sputum if yes, what color is it _____
- Yes No Blood in sputum
- Yes No Swelling of ankles
- Yes No Palpitations (funny heart beats)
- Yes No Trouble breathing when lying flat in bed: if yes, how many pillows do you use _____

General

- Yes No Tire easily/severe fatigue
- Yes No Recent weight change if yes, How much _____
- Yes No Night Sweats
- Yes No Persistent Fevers
- Yes No Chills

Skin

- Yes No Itch
- Yes No Rash if yes, What part of the body _____
- Yes No Change in hair, nails, or color if yes, Explain _____

Head/Eyes/Ears/Nose/Throat

- Yes No Trouble with vision
- Yes No Eye pain/swelling/redness
- Yes No Wear glasses/corrective lenses
- Yes No Loss of smell
- Yes No Nasal obstruction
- Yes No Nosebleeds
- Yes No Sinus problems
- Yes No Post nasal drip
- Yes No Sore throat
- Yes No Hoarseness
- Yes No Sore tongue or gums

Genitourinary

- Yes No Increase in frequency of urination
- Yes No Frequent night time urination How many times per night _____
- Yes No Pain or burning on urination
- Yes No Blood in urine

Digestive System

Yes No Change in appetite if yes, Explain _____
 Yes No Difficulty swallowing if yes, Solids or liquids or both? _____
 Yes No Heartburn
 Yes No Indigestion
 Yes No Feeling of acid in the throat
 Yes No Nausea
 Yes No Vomiting
 Yes No Vomiting blood or dark coffee grounds
 Yes No Rectal bleeding
 Yes No Black, tarry stools
 Yes No Yellow Jaundice
 Yes No Diarrhea
 Yes No Severe constipation

Hematology

Yes No Swollen glands if yes, What part of the body _____
 Yes No Anemia
 Yes No Easy bruising

Allergy/Immunology

Yes No Environmental allergies if yes, To what? _____
 Yes No Allergy shots
 Yes No Seen an allergist if yes, Who? _____
 Yes No "Flu shot" this year
 Yes No "Pneumonia shot" in past

Endocrinology

Yes No Thyroid problems
 Yes No Adrenal problems
 Yes No Excess thirst
 Yes No Excess hunger
 Yes No Excess sensitivity to cold
 Yes No Excess sensitivity to heat

Nervous System

Yes No Severe or New Headaches
 Yes No Dizziness
 Yes No Fainting
 Yes No Convulsions/seizures/fits
 Yes No Sleeplessness
 Yes No Depression
 Yes No Anxiety
 Yes No Memory loss
 Yes No Poor coordination
 Yes No Weakness if yes, What part of the body _____
 Yes No Paralysis if yes, What part of the body _____

Date Reviewed & Discussed with Patient _____

Physician Signature _____

THE EPWORTH SLEEPINESS SCALE

NAME: _____

DATE: _____

How likely are you to doze off, or fall asleep in the following situations, (not feelings of tiredness). This refers to your usual way of life in recent times. 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

Situation

Sitting and reading _____

Watching TV _____

Sitting, inactive in a public place (movies) _____

As a passenger in a car for an hour without a break _____

Lying down in the afternoon _____

Sitting and talking to someone _____

Sitting quietly after lunch (no alcohol) _____

In a car, while stopped for a few minutes _____

TOTAL SCORE _____



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Sleep Questionnaire

Name _____

Date _____

What is your **major complaint** about your sleep? _____

How long have you had this problem? _____

- | | | |
|---|------------------------------|----------------|
| 1. What time do you go to bed ? | Weekdays _____ | Weekends _____ |
| 2. How many minutes does it take to fall asleep on average? | _____ | |
| 3. Do you snore ? | Yes | No |
| 4. Do you sleep alone due to the loudness of your snoring? | Yes | No |
| 5. Do you snort or gasp for air while asleep? | Yes | No |
| 6. Do you or someone else notice that you stop breathing at night? | Yes | No |
| 7. Do you have restless sleep or thrash at night? | Yes | No |
| 8. How many times do you awaken after you fall asleep in general? | _____ | |
| 9. How many times do you urinate at night? | _____ | |
| 10. What time do you start the day ? | Weekdays _____ | Weekends _____ |
| 11. How many hours of sleep do you get? | Weekdays _____ | Weekends _____ |
| 12. Do you feel refreshed when you wake up? | Yes | No |
| 13. Do you have headaches when you wake up? | Yes | No |
| 14. Do you have dry or sore throat when you wake up? | Yes | No |
| 15. Are you excessively sleepy during the day? | Yes | No |
| 16. Does your sleepiness affect your ability to do your job ? | Yes | No |
| 17. Do you feel sleepy at the wheel of a car ? | Yes | No |
| 18. Have you fallen asleep at the wheel of a car ? | Yes | No |
| 19. Do you take naps ? | Yes | No |
| Are your naps refreshing | Yes | No |
| 20. Have you had hallucinations associated with your sleep? | Yes | No |
| 21. Have you had any drop attacks or sudden weakness? | Yes | No |
| 22. Have you felt paralyzed coming out of sleep? | Yes | No |
| 23. Do you have trouble with memory or concentration ? | Yes | No |
| 24. Do you have persistent problems with insomnia ? | Yes | No |
| 25. Do you have night sweats ? | Yes | No |
| 26. Have you noticed swelling of your legs? | Yes | No |
| 27. Have you gained weight recently? | Yes | No |
| How much? _____ | Over what time period? _____ | |
| 28. Are you currently depressed ? | Yes | No |
| 29. Do you have restless legs ? | Yes | No |
| 30. What have you tried to improve your sleep? | _____ | |