Texas Lung Center, P.A.

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Pulmonary Medicine • Critical Care Medicine
Sleep Disorders • Lung Transplantation

Today's Date _____/_____/

Name_____ Social Security #:_____
Last First Middle Initial Birthdate ___/___/___ Age _____

Street /Apt # _____
City State Zip _____

Home Phone (_____) _____ Work Phone (_____) _____
Cell/Other Phone (_____)_____ Marital Status _____
Place of Employment _____ Occupation _____
E-mail address _____
How did you find out about the Sleep Center?_____

(If referred by your physician, please give his/her name and address)

_____

SLEEP HISTORY

1) Briefly describe your current sleep problem. _____
2) How long have you had this problem with your sleep? _____
3) Were there any events associated with the initial onset of your complaint? (Stress, illness, weight gain, etc.)_____
4) Have you had any other evaluations, examinations, or treatment for this sleep problem or any other problem with your sleep? _____No ____Yes

Rate your daytime sleepiness.	None	Mild	Moderate	Severe
Do you take intentional naps?	Never	Sometimes	Often	Always
Do you experience short periods of muscle weakness or loss of muscle control during anger, laughter or excitement?	Never	Sometimes	Often	Always
Do you experience vivid, dreamlike episodes after falling asleep or on awakening?	Never	Sometimes	Often	Always
Do you feel unable to move or paralyzed when falling asleep or waking up?	Never	Sometimes	Often	Always

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What time do you go to bed on weekdays?___:___AM / PM weekends?___:___AM / PM
What time do you get up on weekdays? ___:___AM or PM weekends?___:___AM / PM
How long does it usually take you to fall asleep on weeknights?____ min. weekends?___ min.
Rate how you feel in the morning. __very sleepy __sleepy but waking up __wide awake
When do you function best? ___Morning ___Afternoon ___Evening

While asleep do you	Never	Sometimes	Often	Always
1. Snore?	1	2	3	4
2. Hold your breath?	1	2	3	4
3. Toss and turn or have restless sleep?	1	2	3	4
4. Suddenly awaken choking or gasping for breath?	1	2	3	4
5. Experience chest pains at night?	1	2	3	4
6. Awaken with heartburn or acid reflux?	1	2	3	4
7. Walk or talk in your sleep?	1	2	3	4
8. Have nightmares?	1	2	3	4
9. Grind your teeth?	1	2	3	4
10. Have leg or arm jerks?	1	2	3	4
11. Move about or engage in aggressive behaviors While asleep or upon awakening from sleep?	1	2	3	4
12. Wake up with a dry mouth?	1	2	3	4
13. Wake up with headaches?	1	2	3	4

What is your height? _____What is your weight? _____

How would you rate your current general health?
Very poor _____ Poor _____ Average _____ Good _____ Excellent _____

Do you now or have you ever:
Smoked cigarettes? _____ No ____ Yes
If Yes, how many cigarettes do/did you smoke per day? _____ cigarettes
When did you start?_____ When did you stop?_____
How many years have/did you smoke? _____ Years

Smoked a pipe or cigars or chewed tobacco? _____ No ____ Yes
If Yes, how much per day? _____
For how many years? _____

Used nonprescribed recreational drugs? _____ _____ No ____ Yes
If Yes, what drug(s) do/did you use? _____
For how long? _____

Please list caffeine and beverage consumption per day:

Type	*Quantity cups/cans*	*Type*	*Quantity cups/cans*
Coffee (caffeine)		Hot Tea (caffeine)	
Coffee (No caffeine)		Hot Tea (No caffeine)	
Cold Tea (caffeine)		Cola (caffeine)	
Cold Tea (No caffeine)		Cola (No caffeine)	

Please list your alcohol consumption.

Type	*Quantity*	*How often*
Beer (12 oz.)		
Wine (3-4 oz. Glasses)		
Mixed drinks (1-2 oz.)		

1. Are you having any family or marital problems? _____ If yes, please explain_
_____
_____

2. Are you currently experiencing problems with your memory or concentration? _____
If yes, please explain_____
_____

3. Have you noticed any changes in your mood or irritability levels lately?_____ If yes, please explain?_____
_____

4. Have you been depressed lately?_____ If yes, please explain_____
_____
_____

5. Have you had serious thoughts of suicide or attempts at suicide?_____ If yes, please explain _____
_____

6. Are you having any sexual problems? (Impotency, premature ejaculation, etc.)_____
If yes, please explain_____
_____

7. Are you having any other problems with stress, anxiety, life's pressures? _____
If yes, please explain _____
_____

8. Do you work nights or a rotating shift?_____ If yes, please explain_____
_____

9. Do you often travel across time zones, which affect your sleep / wake schedule?_____
If yes, please explain _____

EPWORTH SLEEPINESS SCALE

MODIFIED-MORNING-AFTERNOON-EVEINING

NAME:_____ DATE:_____

In contrast to just feeling tired, how likely are you to doze off or fall asleep at each specified time of the day (in the morning, afternoon, and evening) in each of the following situations? Even if you have not done some of these things recently, try to work out how they would have effected you. For each time of the day, use the following scale to choose the most appropriate rating for each situation:

0= Would never doze
1= Slight chance of dozing
2= Moderate chance of dozing
3= High chance of dozing

SITUATION	MORNING BEFORE NOON	AFTERNOON N00N- 6 PM	EVENING AFTER 6 PM
		Chance of Dozing	
Sitting & Reading			
Watching TV			
Sitting inactive in a public place (i.e. theater)			
As a passenger in a car for an hour without break			
Lying down rest			
Sitting & talking to someone			
Sitting quietly after a meal without alcohol			
In a car, while stopping for a few minutes in traffic			
TOTAL			

ASSESSMENT OF PATIENT'S BEHAVIOR BY BED PARTNER

Please answer the following questions about your bed partner's behavior over the past six months by circling the word that reflects your opinion.

1. Snores loudly	never	rarely	sometimes	often	always
2. Keeps you awake by loudly snoring	never	rarely	sometimes	often	always
3. Snores loudly in all positions	never	rarely	sometimes	often	always
4. Snoring results in you sleeping separately	never	rarely	sometimes	often	always
5. Breathing pauses and/or snorts are heard	never	rarely	sometimes	often	always
6. Body movements (legs, arms, body jerks etc.)	never	rarely	sometimes	often	always
7. Grinding teeth	never	rarely	sometimes	often	always
8. Acting out dreams	never	rarely	sometimes	often	always
9. Sleep onset within 5 minutes or less	never	rarely	sometimes	often	always
10. Poor concentration and/or short term memory	never	rarely	sometimes	often	always
11. Increased irritability and quick temper	never	rarely	sometimes	often	always

Please estimate the likelihood of you bed partner falling asleep in the following situations.

0=never 1=slight 2=moderate 3=high N/A=no chance to observe

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

Total _____

Patient's Name: _____

Date: _____

Name of Person Completing Questionnaire: _____

Relationship: _____

Today's Visit

Patient Name:____________________________Reason for today's visit:___________________________

Medical Diagnosis: (ie..hypertension, high cholesterol, acid reflux, etc.....)

1.__________________ 2.__________________ 3.________________ 4.__________________

5.__________________ 6.__________________ 7.________________ 8.__________________

Past Surgeries/Procedures:	**Date:**	**Non Surgical Hospitalizations:**	**Date:**
1.________________	__________	1. ________________	________
2.________________	__________	2. ________________	________
3.________________	__________	3. ________________	________
4. ________________	__________	4.________________	________
5. ________________	__________	5.________________	________
6. ________________	__________	6.________________	________

Family History:

	Age:	Alive/Deceased	Cause of Death		Age:	A / D	Cause of Death
Mother:	____	A / D	__________	**Father:**	____	A/D	__________

Any illness:____________________________ Any illness: ____________________________

____

Brother(1)____	A / D	__________	(2) ____	A / D	__________
(3)____	A / D	__________	(4) ____	A / D	__________

Any illness:____________________________ Any illness:____________________________

____

Sister(1) ______ A / D __________ (2) ____ A / D __________

Any illness :____________________________ Any illness:____________________________

(3) ______ A / D __________ (4) ______ A / D __________

Any illness :____________________________ Any illness:____________________________

____

CONTINUE on back of sheet>>

Children:

Son: (1)_____ A / D _____ (2) A / D _____

Any illness : _ _____ Any illness:_____

(3) _____ A / D _____ (4) _____ A / D _____

Any illness:_____ Any illness:_____

Daughter(1):____ A / D _____ (2) _____ A / D _____

____ A / D _____ (3) _____ A / D _____

Immunizations you have had:	**Date:**	**Drug Allergies:**
Influenza:_____	_____	_____
Pneumonia:_____	_____	_____
Tetanus:_____	_____	_____
Diptheria:_____	_____	_____
TB Skin Test: _____	_____	_____
Other:_____	_____	_____

Social History:

Born (where?)_____

How long in metroplex?:_____

Married?_____ How many times?:_____ Divorced?_____ Widowed?_____ Never Married?_____

Work:

Profession?_____

Still Working?_____ Not Working?_____ Retired?_____

Medications you currently take: **(Please include mg / dose/ times per day)**

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

SLEEP CENTER RISK ASSESSMENT FORM

Do you feel unsteady when you walk? NO_____YES_____
If yes, please explain_____

Do you use a ____cane, ____wheelchair, _____ or walker? NO_____ YES_____

Have you had any falls or near falls? NO_____YES_____
If yes, when and where? _____
_____

Have you experienced any agitation, confusion, disorientation or forgetfulness? NO_____YES_____

Are you taking any of the following medications: Anticonvulsants, antidepressants, tranquilizers or sleeping medications? NO_____ YES_____

Do you have physical challenges that require guardian/nursing assistance? NO_____ YES_____

Do you have trouble getting out of bed unassisted? NO_____YES_____

Do you have difficulty hearing? NO_____YES_____

What is your Height_____ and Weight_____?

Do you speak and read English? NO_____YES_____
If no, what language do you speak and read?_____

Do you have a skin reaction/allergy to Latex or Medical Adhesive Tapes? NO_____YES_____
If yes, please explain_____

Are you currently being treated for an active infection NO_____YES_____
If yes, what type of infection?_____

Do you use Supplemental Oxygen while you sleep? NO_____YES_____
If yes, How many Liters/Minute? _____

Do you have any conditions, special needs or requirements during your sleep? IE:

____Diabetes requiring nighttime insulin injections or blood sugar checks
____Kidney Disease requiring Dialysis ____Colostomy Care
____Other (Please explain)_____
_____
_____
_____

Patient's Name:_____