Pulmonary & Sleep Consultants, LLC
Serenity Sleep Institute
www.pscssi.com

Patient name _____ **DOB:** _____.

Referral doctor: _____ **Today's Date**_____

Reason for visit: _____.

Height_____ **Weight** _____ **BMI** _____ **Neck size**_____

Temp_____ **BP**_____/_____ **HR** _____ **RR**_____ **O2 Sat** _____ **%** **FiO2**____

HPI:

Please Circle Yes or No Below:

Asthma	Y	N
COPD	Y	N
Use oxygen	Y	N
Shortness of breath	Y	N
Cough	Y	N
Chest Pain	Y	N
Wheezing	Y	N
Leg swelling	Y	N
Leg pain while walking	Y	N
Wake up at night short of breath (PND)	Y	N
Can NOT sleep flat (orthopnea)	Y	N

Name_____ **Date**_____

♦ Sleep History

Bedtime	PM	AM	**Doctor's Comments:**
Out of bed time	PM	AM	
Please Circle Yes of No			
Snoring	Y	N	
Wake yourself snoring	Y	N	
Stop breathing during sleep	Y	N	
Dry mouth when you wake up	Y	N	
Headache when you wake up	Y	N	
Car accidents because of sleepiness	Y	N	
Near misses because of sleepiness	Y	N	
Do you wake up during sleep	Y	N	
• How many times?			
• Why?			
Insomnia	Y	N	
Daytime naps	Y	N	
• How many?			
• How long?			
If somebody startles you or when you are laughing do you lose control of your muscle tone?	Y	N	
Do you have any vivid dreams upon going to sleep or waking up?	Y	N	
Have you experienced any episodes where you feel you are paralyzed upon going to sleep or waking up? (Like not being able to move from one side to the other?	Y	N	
Do have any weird feeling in your legs (tightness, pain, insects crawling under the skin)? IF YES ANSWER THE NEXT THREE QUESTIONS.	Y	N	
Does it force you to keep moving your legs?	Y	N	
Does the weird feeling improve or go away with moving?	Y	N	
Is this weird feeling worse at night?	Y	N	
Do you sleep walk?	Y	N	
Epworth Sleepiness Score (***to be filled by the nurse)***			

Name_____**Date**_____

Review of Systems: Please answer YES only to significant symptoms

General		
Fatigue	Y	N
Weight Loss	Y	N
Weight Gain	Y	N
Night sweats	Y	N
Fever	Y	N
Chills	Y	N
Eyes		
Double vision	Y	N
Blurred vision	Y	N
Decreased vision	Y	N
Itchy eyes	Y	N
Eye pain	Y	N
Ear, Nose, Throat		
Decrease Hearing	Y	N
Ringing in ears	Y	N
Ear Pain	Y	N
Ear Discharge	Y	N
Hoarseness	Y	N
Nasal bleeding	Y	N
Nasal discharge	Y	N
Difficulty Swallowing	Y	N
Painful swallowing	Y	N
Digestive (GI)		
Nausea	Y	N
Vomiting	Y	N
Heartburn	Y	N
Diarrhea	Y	N
Constipation	Y	N
Blood in stool	Y	N
Black stool	Y	N
Jaundice	Y	N
Abdominal pain	Y	N
Hematologic/Lymphatic		
Swollen Lymph Nodes	Y	N
Bleeding	Y	N
Bruising	Y	N
Allergic Rhinitis		
Runny Nose	Y	N
Post nasal drip	Y	N
Sneezing	Y	N
Nasal congestion	Y	N

Genitourinary		
Painful urination	Y	N
Blood in urine	Y	N
Penile discharge	Y	N
Frequent urination	Y	N
Urinary incontinence	Y	N
Endocrine		
Hot intolerance	Y	N
Tremors	Y	N
Excessive Urination	Y	N
Excessive thirst	Y	N
Musculoskeletal		
Joint pain	Y	N
Joint Swelling	Y	N
Joint redness	Y	N
OB/GYN		
Vaginal Bleeding	Y	N
Vaginal Discharge	Y	N
Breast Lump	Y	N
Breast Discharge	Y	N
Breast Pain	Y	N
Psychiatric		
Depression	Y	N
Suicidal Thoughts	Y	N
Anxiety	Y	N
Hearing Voices	Y	N
Neurological		
Tremors	Y	N
Muscle weakness	Y	N
Headache	Y	N
Numbness	Y	N
SKIN		
Itching	Y	N
Rash	Y	N
Bruising	Y	N
Hail loss	Y	N
Nail changes	Y	N

Name_____ **Date** _____

Past Medical and Surgical History

Psychiatric			Blood Clots in Legs/Arms	Y	N
Anxiety	Y	N	Breast cancer	Y	N
Depression	Y	N	Lung Cancer	Y	N
Bipolar disorder	Y	N	Colon Cancer	Y	N
Post-Traumatic Stress Dis.	Y	N	Kidney or Bladder Cancer	Y	N
Schizophrenia	Y	N	**Nephrology/Urology**		
Neurologic			Kidney stones	Y	N
Dementia	Y	N	Dialysis	Y	N
Stroke	Y	N	BPH (large prostate)	Y	N
TIA	Y	N	**Endocrine**		
Seizure	Y	N	Diabetes	Y	N
Parkinson's	Y	N	Hypothyroidism	Y	N
Peripheral Neuropathy	Y	N	Grave's Disease	Y	N
Nose/sinuses			High Cholesterol/lipids	Y	N
Chronic sinus infection	Y	N	**Rheumatologic**		
Allergies (nose & sinuses)	Y	N	Rheumatoid arthritis	Y	N
Lung			Lupus (SLE)	Y	N
COPD	Y	N	Scleroderma	Y	N
Tuberculosis	Y	N	Fibromyalgia	Y	N
Bronchiectasis	Y	N	**Surgeries**		
Lung fibrosis	Y	N	Heart stents	Y	N
Asbestosis	Y	N	Number of stents		
Asthma	Y	N	CABG (Bypass surgery)	Y	N
PE (blood clot in the lung)	Y	N	Heart Valve replacement	Y	N
Sleep			Thoracic Aneurysm repair	Y	N
Sleep apnea	Y	N	Abdominal Aneurysm repair	Y	N
Insomnia	Y	N	Stents in legs	Y	N
Restless Leg Syndrome	Y	N	Pacemaker placement	Y	N
Narcolepsy	Y	N	Defibrillator placement	Y	N
Heart			Sinus surgery	Y	N
CAD (blockage in heart)	Y	N	Tonsillectomy	Y	N
MI (heart attack)	Y	N	Surgery for sleep apnea	Y	N
Congestive Heart Failure	Y	N	Colon surgery	Y	N
Atrial Fibrillation	Y	N	Gallbladder surgery	Y	N
High Blood Pressure	Y	N	Appendectomy	Y	N
Gastrointestinal			Hysterectomy	Y	N
Heartburn/Reflux	Y	N	Hernia Surgery	Y	N
Stomach ulcer	Y	N	Cataract surgery	Y	N
Ulcerative Colitis	Y	N	Joint replacement	Y	N
Crohn's Disease	Y	N	Joint Surgery	Y	N
Hepatitis A B C D	Y	N	Spine Surgery	Y	N
Cirrhosis	Y	N			
Hematologic/Cancers					
Leukemia	Y	N			
Lymphoma	Y	N			
Bleeding disorder	Y	N			
Anemia	Y	N			

Name_____ **Date** _____

Social History:

Current Job _____ **Previous Job**_____

Marital Status: Married Single Divorced Widow Separated Other

Smoking Never
Current Yes No Packs/ Day Number of years
Quit Yes When? Packs/ Day Number of years

Chew/Snuff tobacco No Yes

Exposure

Second-hand smoke	No	Yes	Now	Past
Asbestos	No	Yes	Now	Past
Beryllium	No	Yes	Now	Past
Tuberculosis (TB)	No	Yes	Who?	When?
TB skin test (PPD)?	No	Yes	Positive	Negative
Were you treated?	No	Yes		
If yes, what medications?				
If yes, how long?				

Pets	No	Yes	What	
Birds	No	Yes	What	
Hot Tub (NOT Jacuzzi)	No	Yes		
Alcohol	No	Yes	How much?	How often?
Coffee or caffeine containing beverages	No	Yes	How much?	How often?
Do you use illegal drugs?	No	Yes	What kind?	
Did you use illegal drugs in the past?	No	Yes	What kind?	
Recent Travel in the last few months?	No	Yes	Where?	
			When?	

Family History:

- Asthma No Yes Who
- COPD No Yes Who Smoker Yes No

Father	Alive	No	Yes	Age	Diseases
Mother	Alive	No	Yes	Age	Diseases