Annapolis Asthma, Pulmonary & Sleep Specialists

Patient History Questionnaire

Name: _____ **Date of Birth:**_____

Medical History (please check all that apply):

☐Asthma ☐Hay fever ☐COPD ☐Pneumonia ☐Sinusitis ☐Sarcoidosis ☐GERD
☐High blood pressure ☐Heart disease ☐Congestive heart failure ☐Stroke ☐Diabetes
☐Peripheral vascular disease ☐Kidney disease ☐Liver disease ☐Cancer ☐Sleep apnea

Surgical History (please list most recent first):

Surgery: _____ Date: _____
Surgery: _____ Date: _____

Hospitalizations (please list most recent first):

_____
_____
_____

Allergies (please check all that apply):

☐Penicillin ☐Sulfa ☐Aspirin ☐Codeine ☐X-Ray contrast dye ☐Shellfish
☐No known drug allergies ☐Other: _____

Occupational and Environmental History:

Occupations: _____
Exposures (please check all that apply):
☐Asbestos ☐Chickens ☐Birds ☐Dogs ☐Cats ☐Farm animals
☐Any specific dusts, fumes, gases, or chemicals: _____

Social History:

Marital Status: ☐Married ☐Widowed ☐Divorced ☐Single ☐Other
Children: 0 1 2 3 ☐Other:_____
Tobacco: ☐Never smoked ☐Current smoker (_____packs/day for _____years)
☐Smokeless tobacco ☐Quit on _____ (_____packs/day for _____years)
Alcohol: ☐None ☐Occasional ☐2-3 times/week ☐Daily
Exercise: ☐None ☐Occasional ☐2-3 times/week ☐Daily

Family History:

Father: ☐Alive ☐Deceased Major Illnesses: _____
Mother: ☐Alive ☐Deceased Major Illnesses: _____
Bro/Sis: ☐Alive ☐Deceased Major Illnesses: _____
Bro/Sis: ☐Alive ☐Deceased Major Illnesses: _____
Bro/Sis: ☐Alive ☐Deceased Major Illnesses: _____

Name: _____ **Date of Birth:**_____

System Review (please check all that apply):

Constitutional: □Fever □Chills □Night sweats □Weight gain (___lbs) □Weight loss (____lbs)

Allergic: □Hay fever □Hives □Eczema

Cardiovascular: □Chest pain/pressure/tightness □Palpitations □Swelling in ankles
□Sudden awakening with shortness of breath

Endocrine: □Excessive hunger or urination □Heat or cold intolerance

Eyes: □Visual changes □Redness □Itching

ENT: □Headache □Postnasal drip □Hoarseness □Nasal discharge

Gastrointestinal: □Heartburn □Nausea/vomiting □Abdominal pain
□Change in bowel habits □Difficulty swallowing

GU: □Urinary frequency/pain/burning/blood

Heme/Lymph: □Easy bruising/bleeding □Swollen lymph glands

Musculoskeletal: □Joint pain/swelling/redness

Neurologic: □Fainting □Blackouts □Seizures

Psychiatric: □Depression □Anxiety □Panic attacks

Pulmonary: *(Please circle all that apply)*
Cough: none / occasional / most days ; for _____ days/wks/mos/yrs
Sputum Production: none / rarely / most days ; for _____ days/wks/mos/yrs
clear / white / yellow / green / blood
Wheezing: none / occasional / most days ; for _____ days/wks/mos/yrs
with exercise / with exposure to cold air
Shortness of Breath: at rest / with household chores
going up one flight of stairs / walking less than 1 block
Chest Pain: none / with deep breath / with coughing / with_____
*Pulmonary symptoms are made worse by: _____
_____

Skin: □Chronic rash □Change in color or texture of skin

Sleep: □Insomnia □Loud snoring □Excessive daytime sleepiness

Medications (please list all current medications and any supplemental or herbals you are taking):

Medication Name	Strength	Quantity	Frequency
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

MEDICAL RECORDS AUTHORIZATION

Please review this document carefully as it describes how your medical information will be accessed and disclosed to individuals. Please check the applicable boxes and sign and date at the bottom of the page. Thank you.

Patient Name: _____ Date of Birth: _____

DISCLOSURE TO FAMILY AND FRIENDS

☐ I authorize Annapolis, Asthma, Pulmonary & Sleep Specialists to disclose and discuss information related to my care and treatment to the following individuals:

Name: _____ Phone Number: _____

Name: _____ Phone Number: _____

Name: _____ Phone Number: _____

Name: _____ Phone Number: _____

☐ I am a resident at the following facility (nursing home, assisted living facility, rehabilitation center, etc.) and I authorize Annapolis, Asthma, Pulmonary & Sleep Specialists to disclose and discuss information related to my care and treatment to any and all representatives associated with their company.

Facility: _____

☐ I do NOT want Annapolis Asthma, Pulmonary & Sleep Specialists to disclose information related to my care and treatment to any family or friends without my written consent or legal authorization.
(Please note that checking this box indicates that we will not speak with any individuals, including immediate family members.)

_____ _____

Patient Signature **Date**

Annapolis Asthma, Pulmonary & Sleep Specialists

Sleep Questionnaire

Name: _____ **Date of Birth:**_____

Please answer the following questions based on any symptoms you are currently experiencing or have experienced in the past.

PART A	YES	NO
1. Do you have trouble falling asleep?	☐	☐
2. Do you have trouble staying asleep?	☐	☐
3. Do you awaken feeling refreshed?	☐	☐
4. If you do wake up in the middle of the night, can you fall back asleep within 10-15 minutes?	☐	☐
5. If you do wake up in the middle of the night, does it take you at least 40 minutes or more to fall back asleep?	☐	☐

PART B

1. How do you sleep on vacations or in other rooms which are not your bed?
   - ☐ Same
   - ☐ Better
   - ☐ Worse

	YES	NO
2. Do you look at the clock at night?	☐	☐
3. Do you get upset when you cannot fall asleep?	☐	☐
4. Are you generally an anxious person?	☐	☐
5. Do you get up and go to sleep on the couch?	☐	☐
6. Do you feel your bedroom is like a “torture chamber”?	☐	☐

7. Have you been a poor sleeper your whole life?
8. Is there any one event which precipitated your sleep problem?

PART C	YES	NO
1. Are you worried about going out in crowds or are you scared of heights or flying in an airplane?	☐	☐
2. Do you sometimes feel depressed?	☐	☐
3. Have you lost interest in activities you used to find enjoyable?	☐	☐
4. Do you cry easily?	☐	☐
5. Have you ever had a panic attack?	☐	☐

Name: _____ **Date of Birth:**_____

PART D	YES	NO
1. Do you ever have jumpy or restless legs at night, in the movies, when you get in bed, or in airplanes?	☐	☐
2. Do you have to get up and massage your legs because they feel restless or uncomfortable?	☐	☐

PART E	YES	NO
1. Do you have any caffeinated beverages or even decaffeinated beverages after 2 o'clock in the afternoon?	☐	☐
2. Do you eat chocolate at night?	☐	☐
3. Is the bed environment warm?	☐	☐
4. Is the bed environment noisy?	☐	☐
5. Do you get at least 8 hours of sleep at night?	☐	☐
6. Do you have a lot of pain in your joints, arms, or legs at night?	☐	☐
7. Do you smoke cigarettes after 6 o'clock in the evening?	☐	☐

PART F	YES	NO
1. Do you prefer to go to the bed late (perhaps after midnight), and wake up late?	☐	☐
2. If you do, do you feel refreshed?	☐	☐
3. Do you do shift work?	☐	☐
4. Do you take naps during the day?	☐	☐
5. If you do, are they refreshing?	☐	☐

PART G	YES	NO
1. Do you snore?	☐	☐
2. If so, do you snore loudly?	☐	☐
3. Do you ever wake yourself up with a snore or a grunt?	☐	☐
4. Has your weight increased by 15 or more pounds within the past 5 years?	☐	☐
5. Do you ever wake up short of breath?	☐	☐
6. Do you ever wake up wheezing?	☐	☐
7. Do you ever wake up choking?	☐	☐

PART H	YES	NO
1. Do you have nightmares that you can recall?	☐	☐
2. Do you wake up scared or confused?	☐	☐
3. Do others tell you about episodes in which you awaken scared and confused?	☐	☐
4. Have you ever experienced sleep walking as an adult or child?	☐	☐
5. Do you ever physically act out your dream with a lot of movement or kicking?	☐	☐

Name: _____ **Date of Birth:**_____

THE EPWORTH SLEEPINESS SCALE

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired? This refers to your usual way of life in recent times. Even if you have not done some of these things recently try to work out how they would have affected you. Use the following scale to choose the most appropriate number for each situation:

0 = no chance of dozing
1 = slight chance of dozing
2 = moderate chance of dozing
3 = high chance of dozing

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

Name: _____ **Date of Birth:**_____

Fatigue Severity Scale (FSS) of Sleep Disorders

The Fatigue Severity Scale (FSS) is a method of evaluating the impact of fatigue on you. The FSS is a short questionnaire that requires you to rate your level of fatigue.

The FSS questionnaire contains nine statements that rate the severity of your fatigue symptoms. Read each statement and circle a number from 1 to 7, based on how accurately it reflects your condition during the past week and the extent to which you agree or disagree that the statement applies to you.

- A low value (e.g., 1) indicates strong disagreement with the statement, whereas a high value (e.g., 7) indicates strong agreement.
- It is important that you circle a number (1 to 7) for every question.

FSS Questionnaire							
During the past week, I have found that:	**Disagree <--------> Agree**						
My motivation is lower when I am fatigued.	1	2	3	4	5	6	7
Exercise brings on my fatigue.	1	2	3	4	5	6	7
I am easily fatigued.	1	2	3	4	5	6	7
Fatigue interferes with my physical functioning.	1	2	3	4	5	6	7
Fatigue causes frequent problems for me.	1	2	3	4	5	6	7
My fatigue prevents sustained physical functioning.	1	2	3	4	5	6	7
Fatigue interferes with carrying out certain duties and responsibilities.	1	2	3	4	5	6	7
Fatigue is among my three most disabling symptoms.	1	2	3	4	5	6	7
Fatigue interferes with my work, family, or social life.	1	2	3	4	5	6	7
	Total Score:						

Scoring your results

Now that you have completed the questionnaire, it is time to score your results and evaluate your level of fatigue. It's simple: Add all the numbers you circled to get your total score.

The Fatigue Severity Scale Key

A total score of less than 36 suggests that you may not be suffering from fatigue.

A total score of 36 or more suggests that you may need further evaluation by a physician.