

PLACE LABEL HERE.
IF LABEL NOT AVAILABLE, WRITE IN PT NAME & MR#

Is relieved by antacid medications? ... Yes No
Is relieved with milk or eating? ... Yes No
Occurs while eating or immediately after? ... Yes No

If you have had a change in bowel habit recently answer the following:

Crampy pain in the abdomen? ... Yes No
Alternating diarrhea and constipation? ... Yes No
Pain during or after bowel movements? ... Yes No
Blood in the stool? ... Yes No
Black stools? ... Yes No
Require use of strong laxatives or enemas? ... Yes No

Have you had:

Burning on urination? ... Yes No
Loss of control of the bladder? ... Yes No
Dark colored urine? ... Yes No
Blood in the urine? ... Yes No
Trouble starting to urinate? ... Yes No
A kidney stone? ... Yes No
Do you get up frequently at night to urinate? ... Yes No

Do you frequently have:

Back pain? ... Yes No
Muscle aches? ... Yes No
Muscle weakness? ... Yes No
Joint problems? ... Yes No

Do you have:

Skin problems/rashes? ... Yes No
Unusual moles? ... Yes No
Have you had skin cancer? ... Yes No
Easy bruising? ... Yes No
Allergies/Hay fever? ... Yes No

Are you depressed? ... Yes No
If yes, are you receiving treatment? ... Yes No
Do you have any other mental health problems? ... Yes No
If yes, please explain:

To be answered by WOMEN only:

Are you still having regular monthly periods? ... Yes No
Date of last menstrual period
Do you have regular cancer test of the cervix? ... Yes No
Date of last test
How many children How many miscarriages?

To be answered by MEN only:

Have you ever had:
Loss of sexual activity? ... Yes No
If yes, for how long?
Prostate trouble? ... Yes No

Have you had:

An ulcer? ... Yes No
A hiatus hernia? ... Yes No
Gallstones? ... Yes No

To Be answered by ALL:

Please add any additional information that you think might be helpful:

Thank you for taking the time to complete this history.

Completed by: Patient/Guardian Date

Reviewed by: Staff Name Date

PATIENT'S SLEEP HEALTH HISTORY WORKSHEET

Confidential Record: Information contained here will not be released except when you have authorized us to do so.

Last Name First Birth Date

Describe briefly your present medical symptoms:

SLEEP QUESTIONS

What time do you go to bed? How long does it take you to fall asleep?
How many times do you wake up during the night? How long do you stay awake?
Do you get up to go to the bathroom? How many times? How long do you stay awake?
Do you snore? All the time Most of the time Some of the time Rarely Never
Only on your back?
Has anyone told you that you stop breathing during sleep?
Do you jerk your legs or arms during sleep?
Do you ever wake up choking or gasping for air? snoring?
What time do you get out of bed in the morning? Do you have a headache when you wake up?
How do you feel when you get out of bed in the morning?
During the day are you sleepy? tired? fatigued? How long have you felt this way?
Do you fall asleep during the day? If yes, how many times? How long each time on average?
Do you feel better after napping? Yes No
Have you fallen asleep while driving?
Have you ever awakened and found that you were completely paralyzed and couldn't move any muscles?
When you were laughing or angry have your muscles ever given out, for example, you dropped things, or you fell to the ground?
How much weight have you gained in the last 5 years? Lost in the last 5 years?
Can you breathe through your nose during the day? at night?
Do you still have your tonsils? your adenoids?
Have you had a serious injury to your face, head or neck?
How many cups of coffee or caffeinated beverages do you drink in a day?
Does anyone in your family have a sleeping problem such as sleep apnea or narcolepsy?

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 = would never doze 1 = slight chance of dozing 2 = moderate chance of dozing 3 = high chance of dozing

Table with 2 columns: SITUATION and CHANCE OF DOZING. Situations include Sitting and Reading, Watching TV, Sitting in a public place, etc.

NOT A CHART DOCUMENT

OTHER MEDICAL PROBLEMS

List the diseases/health problems that you have now.

List other serious diseases, injuries or accidents you have had: _____

List the names and dates of operations you have had: _____

Name any drugs to which you are allergic: _____

Please list all medications you are taking now, **how often you take them and the dose**, if known. Be sure to list prescription and non-prescription nasal sprays. Include over-the-counter medicines you take on a regular basis.

SOCIAL HISTORY

Smoking _____ Cigarettes/Cigars - Age began _____ Age stopped _____ Average number of packs daily _____

Do you regularly drink alcohol? _____ Amount per day _____

Have you ever used illegal drugs? _____ What drugs? _____ Last used? _____

Approximate date of last flu shot? _____ Have you had the pneumonia shot? _____

Approximate date of last tetanus shot _____

What is your highest educational level? _____ What is your job? _____

What hours/shifts do you work? _____

If retired, what did you do before retiring? _____

Do you get regular exercise? Yes No If yes, please describe _____

FAMILY HISTORY	If Living		If Deceased	
	Sex	Age	Health	Cause
Father				
Mother				
Brothers/Sisters (Circle Sex)				
	M F			
	M F			
	M F			
	M F			
	M F			
	M F			
Husband/Wife				
Sons/Daughters (Circle Sex)				
	M F			
	M F			
	M F			
	M F			
	M F			
	M F			

Do you know of any blood relative who has or had: (check and give relationship)

- | | | | |
|---|--|---|---|
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Stomach Ulcers | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Colitis | <input type="checkbox"/> Mental Illness |
| <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Cancer/Leukemia | <input type="checkbox"/> Suicide |
| <input type="checkbox"/> Rheumatic Heart | <input type="checkbox"/> Bleeding tendency | <input type="checkbox"/> Thyroid Problems | |
| <input type="checkbox"/> Birth Defects of the Heart | <input type="checkbox"/> Blood Clots | <input type="checkbox"/> Hay Fever | |

PLEASE CHECK ANY ITEMS THAT APPLY TO YOU:

- | | | | | |
|--|--|--|--|--|
| <input type="checkbox"/> fever | <input type="checkbox"/> dry mouth in A.M. | <input type="checkbox"/> ringing in ears | <input type="checkbox"/> double vision | <input type="checkbox"/> sore tongue |
| <input type="checkbox"/> blurred vision | <input type="checkbox"/> chills | <input type="checkbox"/> stuffy nose | <input type="checkbox"/> ear pain | <input type="checkbox"/> bleeding gums |
| <input type="checkbox"/> change in hearing | <input type="checkbox"/> change in vision | <input type="checkbox"/> night sweats | <input type="checkbox"/> hoarseness | <input type="checkbox"/> problems swallowing |

- Do you frequently have severe headaches?** Yes No
- Do they cause visual trouble? Yes No
- Do they awaken you from sleep? Yes No
- Does aspirin relieve them? Yes No

Have you had:

- A seizure (convulsion)? Yes No
- Problems remembering things? Yes No
- Problems concentrating? Yes No
- A stroke or "mini-stroke"? Yes No
- Spells of weakness of an arm or leg? Yes No

Do you have:

- Dry, itchy skin? Yes No
- Hair loss? Yes No
- Excess thirst? Yes No
- Excess hunger? Yes No
- Frequent urination? Yes No
- Are you intolerant to heat? Yes No
- Are you intolerant to cold? Yes No

Have you ever had shortness of breath? Yes No

- Doing your usual work? Yes No
- Climbing a flight of stairs? Yes No
- Which awakens you at night? Yes No
- Which causes you to cough? Yes No
- Accompanied by wheezing? Yes No
- Do you have a chronic cough? Yes No
- Do you cough up much sputum? Yes No
- Have you ever coughed up blood? Yes No
- Have you ever had phlebitis or inflamed leg veins? Yes No
- Have you ever had a blood clot? Yes No

Have you ever had chest pain or tightness which begins:

- When exerting yourself? Yes No
- When walking against the wind? Yes No
- When walking up a hill? Yes No
- When walking fast? Yes No
- When walking in cold weather? Yes No
- When upset or excited? Yes No
- If you have chest pain, please explain _____
- Do you also have pain down the arm? Yes No
- Do you sleep on more than one pillow? Yes No

Have you had:

- A heart attack? Yes No
- Palpitations (intermittent fast heart beat)? Yes No
- Leg pain when walking? Yes No
- Leg cramps at night? Yes No
- Swelling in the ankles? Yes No

Do you frequently have:

- Nausea and vomiting? Yes No
- Loss of appetite? Yes No

Have you had:

- An ulcer? Yes No
- A hiatus hernia? Yes No
- Gallstones? Yes No

Have you recently had pain in the stomach which: (Check)

- Occurs 1-2 hours after a meal? Yes No
- Is brought on by eating fried or gassy foods? Yes No
- Awakens you at night? Yes No