NWO Pulmonary, Critical Care & Sleep

Phone: 419-843-7800 Fax: 419-843-3444
Email: nwopccs@toledoclinic.com

Name: **DOB:** **Age:** **Date:**

Pharmacy: **PCP:** **Referring Dr.**

Chief Complaint:

When did the problem begin?

Have you ever had a sleep study? If yes, where and when?

Do you have home oxygen?

Medical Equipment Company used:

Your Medical History:

__ Allergic Rhinitis
__ Angina
__ Arthritis
__ Asthma
__ Bronchitis
__ Cancer
__ COPD
__ Congestive Heart Failure
__ Depression
__ Dizziness
__ Diabetes (insulin or non-insulin dependent)
__ Emphysema
__ GERD
__ Headache
__ Heart Attack
__ High Blood Pressure
__ Kidney Stones
__ Liver Disease/Hepatitis
__ Low Blood Pressure
__ Pneumonia
__ Prior Intubations
__ Shortness of Breath
__ Sinus
__ Stroke
__ Thyroid (hypo/hyper)
__ Tuberculosis
__ Ulcers
Other: _____

Surgical History (with Approximate Date):

_____ Adenoids _____ Heart _____ Stents _____ Angioplasty
_____ Hernia _____ Stomach _____ Appendix _____ Bypass
_____ Internal Cardiac Defibrillator _____ Lung (surgery or biopsy)
_____ Tonsils _____ Gallbladder _____ Pacemaker Other:

NWO Pulmonary, Critical Care & Sleep

Phone: 419-843-7800 Fax: 419-843-3444

Email: nwopccs@toledoclinic.com

Name: **DOB:** **Date:**

Medications/Supplements:

Name	Dosage	Frequency

Allergies	Reaction

Family History:

__ Angina __ Arthritis __ Asthma __ Cancer (Type) _____

__ CHF __ COPD __ Depression __ Diabetes

__ Emphysema __ Headaches __ Heart Attack __ High Blood Pressure

__ Insomnia __ Kidney Disease __ Liver Disease/Hepatitis

__ Narcolepsy __ Sleep Apnea (OSA) __ Restless Legs __ Thyroid (hyper/hypo)

Other:_____

NWO Pulmonary, Critical Care & Sleep

Phone: 419-843-7800 Fax: 419-843-3444
Email: nwopccs@toledoclinic.com

Name: _____ **DOB:** _____ **Date:** _____

Physical Activity:

- Are you: _____ Active _____ Somewhat Active _____ Not Active
- Height:_____ Weight:_____
  Has your weight changed? ___ Yes ___ No If yes, how much over how long?

Social History:

- Caffeine Use: _____ If yes, how much per day? _____
- Do you smoke? ___ Yes ___ No
  - If yes, when did you start smoking? _____ Packs per Day?_____
  - If former smoker, when did you quit? _____ How long did you smoke? ____
- Do you use alcohol? ___ Yes ___ No If yes, how much per day? _____
- Illegal Drug/Substance Abuse? _____

Psychosocial History:

Marital Status: _____ Married _____ Divorced _____ Single _____ Widow
Family Support: ____ Excellent ____ Good ____ Fair ____ Poor ____ None
Occupation: _____ If retired, when did you retire: _____
Shift Worker: ___ Yes ___ No If yes, what shifts? _____
Exposure to: ___ Fumes ___ Chemicals ___ Dust ___ Asbestosis Other: _____
Do you have job stress: ___ Yes ____ No
How long, on average, does it take you to fall asleep? _____(Minutes/Hours)
How many hours do you sleep at night? _____
What time do you go to bed on WEEKDAYS: _____ Time up? _____
What time do you go to bed on WEEKENDS: _____ Time up? _____
How many times do you wake up at night? _____
Do you sleep better away from home? _____ Yes _____ No
Do you use sleeping pills, tranquilizers, or sedatives to sleep? _____ Yes _____ No

- If yes, name and dose of medication: _____

NWO Pulmonary, Critical Care & Sleep

Phone: 419-843-7800 Fax: 419-843-3444

Email: nwopccs@toledoclinic.com

Name: **DOB:** **Date:**

The Epworth Sleepiness Scale:

How likely are you to doze off of 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 had some of these things recently, try to work out how they would have affected you. Use the scale below 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:	**Scale:**
1. Sitting and reading:	_____
2. Watching TV:	_____
3. Sitting inactive in a public place (theatre/meeting):	_____
4. As a passenger in a car for an hour, without a break:	_____
5. Lying down to rest in the afternoon, circumstances allowing:	_____
6. Sitting and talking to someone:	_____
7. Sitting quietly after lunch, without alcohol:	_____
8. In a car while stopped for a few minutes in traffic:	_____
Total:	_____

Daytime Functioning:

1. How often do you have daytime sleepiness? (feeling sleepy or struggling to stay awake)
   Daily Weekly Monthly
2. How long ago did your daytime sleepiness start? _____
3. How does your sleepiness over the past year compare to prior years?
   Better Worse No change
4. Do you nap during the day? ___ Yes ___ No If yes, what is the average number of times per day? Weekdays: _____ Weekends: _____
   If yes, how long is your average nap? Weekdays: _____ Weekends: _____
   If yes, are you refreshed by your naps? ___ Yes ___ No

5. Do you feel constantly tired and fatigued? ____ Yes ____ No
6. Do you have a difficult time staying awake at work? ____ Yes ____ No
7. Do you doze off while driving? ____ Yes ____ No
8. Have you ever felt weak when you laugh, got angry, or surprised? ___ Yes ____ No
   If yes, please describe: _____
   How often has this happened? _____
   When did this first start? _____
9. Have you ever been unable to move your body as you were falling asleep or waking up?
   ____ Yes ____ No If yes, please describe: _____

During the evening/night:

1. Do you have an urge to move your legs upon relaxing or falling asleep? ____Yes ___ No
   If yes, please describe: _____
   Does this feeling keep you from falling asleep? ____ Yes ____ No
2. Do you fall asleep more easily in a chair or couch than in bed? ____ Yes ____ No
3. Do you watch TV, read, or eat in bed prior to falling asleep? ____ Yes ____ No
4. Have you been told that you stop breathing while sleeping? ____ Yes ____ No
   If yes, how often? ____ Rarely ____ Occasionally ____ Frequently
   If yes, when did it start: _____
5. Do you ever awaken at night choking or feeling short of breath? ____ Yes ____ No
   If yes, how often? ____ Rarely ____ Occasionally ____ Frequently
6. Do you snore? ____ Yes ____ No
   If yes, how often? ____ Rarely ____ Occasionally ____ Frequently
7. Does your sleep position effect your snoring? ____ Yes ____ No
   If yes, please describe: _____
8. Does your snoring or kicking prevent someone from sleeping in the same bed?
   ___Yes ___ No
9. Have you ever awakened yourself by kicking your legs at night? ____ Yes ____ No
10. Has your bed partner complained of your legs kicking at night? ____ Yes ____ No
11. Do you have vivid dreams shortly after falling asleep at night? ____ Yes ____ No
12. Do you have nightmares? If so, how frequently: _____ ____ Yes ____ No
13. Do you grind or clench your teeth at night? ____ Yes ____ No
14. Do you walk in your sleep? ____ Yes ____ No
15. Do you talk in your sleep? ____ Yes ____ No
16. Do you toss and turn at night? If yes, how often? _____ ____ Yes ____ No
17. Has anyone observed unusual movement during your sleep? ____ Yes ____ No
18. Are you easily awakened by noise or light at night? ____ Yes ____ No
19. Do you awaken at night to urinate? If so, how many times? ____ ____ Yes ____ No

20. Do you have trouble falling asleep? ____ Yes ____ No
21. Do you awaken at night and have trouble falling back asleep? ____ Yes ____ No
22. Do you awaken at night with thoughts racing through your mind? ____ Yes ____ No

In the morning:

1. Do you awaken early in the morning and cannot go back to sleep? ____ Yes ____ No
2. Are you bothered by walking up too early and not being able to fall back asleep? ____ Yes ____ No
3. Do you wake up in the morning with a headache? ____ Yes ____ No
4. Do you awaken feeling refreshed? ____ Yes ____ No
5. Do you find it difficult to get out of bed in the morning? ____ Yes ____ No
6. Do you have any other comments on your sleep? _____

NWO Pulmonary, Critical Care & Sleep

Name: **DOB:** **Date:**

Review of Systems: In the last month, have you had any of the following symptoms? Circle one.

General:		**Cardiac:**	
Loss of energy	Yes or No	Heart Problems	Yes or No
Fever/Chills	Yes or No	Chest pain	Yes or No
Night sweats	Yes or No	Heart murmurs	Yes or No
		Heart attack	Yes or No
Skin:		Fainting	Yes or No
Rashes	Yes or No	Difficulty laying	Yes or No
Change in skin color	Yes or No		
Unhealed sores	Yes or No	**Gastrointestinal:**	
		Abdominal pain	Yes or No
Blood:		Heartburn	Yes or No
Unusual bleeding	Yes or No	Nausea/Vomiting	Yes or No
Easy bruising	Yes or No	Diarrhea	Yes or No
Anemia	Yes or No	Constipation	Yes or No
Enlarged glands	Yes or No	Blood in stool	Yes or No
Endocrine:		**Urinary:**	
Heat/Cold intolerance	Yes or No	Burning while urinating	Yes or No
Hair growth/loss	Yes or No	Blood in urine	Yes or No
Increased thirst	Yes or No	Increased urine	Yes or No
Increased hunger	Yes or No	Flank pain	Yes or No
		Trouble in start/stop	Yes or No
Eyes/Ears/Mouth:			
Vision trouble	Yes or No	**Muscle/Skeleton:**	
Double vision	Yes or No	Joint pain	Yes or No
Eye pain	Yes or No	Morning stiffness	Yes or No
Hearing problems	Yes or No	Back problems	Yes or No
Ringing in ears	Yes or No		
Dizziness		**Neurologic:**	
Dental problems	Yes or No	Blackouts	Yes or No
Difficulty swallowing	Yes or No	Seizures	Yes or No
Mouth sores	Yes or No	Frequent headaches	Yes or No
Hoarseness	Yes or No	Muscle weakness	Yes or No
		Trouble talking	Yes or No
Lungs/Nose:		Balance problems	Yes or No
Nose bleeds	Yes or No	Memory problems	Yes or No
Cough	Yes or No		
Runny nose	Yes or No	**Emotion:**	
Shortness of breath	Yes or No	Mood swings	Yes or No
Wheezing	Yes or No	Crying spells	Yes or No
Cold	Yes or No	Psychiatric	Yes or No

The Toledo Clinic
Choose well, feel better.™
www.toledoclinic.com

NWO Pulmonary, Critical Care & Sleep

1661 Holland Rd, Maumee Oh 43537

P: 419-843-7800 F: 419-843-3444

Thank you for choosing Pulmonary and Critical Care Specialists for your specialized care. For our physicians to provide you with the best service, it is important that you keep all scheduled appointments.

We understand that there may be a need to cancel, change or reschedule your appointment. We ask that you make any changes **AT LEAST 24 HOURS PRIOR** to your scheduled visit.

Our office makes appointment reminder calls at least 48 hours prior to your appointment. Please make sure that we have the correct contact information on file for you.

Any appointment that is not cancelled within the 24-hour period will be subject to a **$200** "no-show/late cancel" fee. New patient no shows will not be rescheduled.

Our physicians and staff look forward to working with you.

SIGNATURE: _____ DATE: _____