

Pulmonary and Sleep Medicine Questionnaire

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Confidential

Name: _____ Date: _____ Age: _____ Weight _____

Health History

Please check any problem or illness you have or have had.

- | | | | |
|--|---|--|--|
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Low Blood Pressure |
| <input type="checkbox"/> Fainting | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Headaches | <input type="checkbox"/> Ringing of the ears |
| <input type="checkbox"/> Black Outs | <input type="checkbox"/> Hemophilia(Bleeder) | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Hernia |
| <input type="checkbox"/> prostate | <input type="checkbox"/> Mental Problems | <input type="checkbox"/> Back Trouble | <input type="checkbox"/> Gout |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Asthma | <input type="checkbox"/> Allergies | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Kidney Trouble | <input type="checkbox"/> Bladder Trouble | <input type="checkbox"/> Eye Trouble |
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Hearing Trouble | <input type="checkbox"/> Meningitis | <input type="checkbox"/> Heartburn/Reflux |
| <input type="checkbox"/> Impotence | <input type="checkbox"/> Depression | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Muscle Cramps | <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Diabetes |

Other Medical issues (i.e diabetes, hypotension)

Surgical History (i.e tonsillectomy)

Family History

Does anyone in your family have a sleep cardiac or pulmonary disorders? Yes No

Relationship to you:

Describe the problem:

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Have you or a blood relative had any type of autoimmune disease (i.e. Rheumatoid arthritis, Systemic Lupus, Sclerodema)? Yes No

Exposure History

Have you regularly been exposed to:

- Asbestos Yes No
- Silica (sandblasting, glass, mining) Yes No
- Coal Mining Yes No
- Other fumes/chemicals which are concerning Yes No

Have you ever taken drugs such as:

- Steroids (i.e. prednisone)? Yes No
- Dietary Supplements? Yes No
- Amiodarone? Yes No
- Chemotherapeutic drugs (i.e. bleomycin, cytoxan)? Yes No

How much of the following fluids do you drink?

- | | <u>During a typical day</u> | <u>Within 2 hrs before bedtime</u> |
|-----------------------------------|--|------------------------------------|
| • Coffee: Caffeinated | ___ cups | ___ cups |
| Decaffeinated | ___ cups | ___ cups |
| • Tea | ___ cups | ___ cups |
| • Soda: Caffeinated | ___ cups | ___ cups |
| Decaffeinated | ___ cups | ___ cups |
| • Beer | ___ cups | ___ cups |
| • Wine | ___ cups | ___ cups |
| • Other Alcoholic Beverages | ___ cups | ___ cups |
| • Any problems with alcohol abuse | <input type="checkbox"/> Yes <input type="checkbox"/> No | |

How much tobacco do you smoke during a 24 hour period? For how many years?

- Pack of Cigarettes _____
- Cigars _____
- (Pipe) bowls _____ If you quit, then when _____

Have you used or been exposed to:

- Marijuana Yes No
- Cocaine Yes No
- Hallucinogens (LSD, Mescaline, Angel dust, etc.) Yes No
- Stimulants (uppers) Yes No
- Depressants (downers) Yes No
- Narcotics (heroin, morphine, opium, etc.) Yes No

Medication History

Please list the name and dose(in mg) of all medications that you take now or within the past 30 days

<u>Medication</u>	<u>Dose</u>	<u>What for?</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

How many times each week do you participate in a sport or partake in some form of exercise?
_____/week

Have you had any weight gain/loss in the past 1 to 3 years? Yes No

Do you snore? Yes No

Have you ever been told that you stop/pause breathing while you sleep? Yes No

Are you currently exposed to any animals (i.e. birds, snakes, cats/ Yes No

Have you traveled anywhere recently? Yes No

With regards to your current problem, do you have:

Fevers? Yes No

Chills? Yes No

Palpitations? Yes No

Chest Pain? Yes No

Shortness of Breath? Yes No

Productive or non productive cough? Yes No

Cough up blood? Yes No

How many flights of stairs can you walk up briskly? _____

Please complete further if you are here for sleep evaluation or have daytime sleepiness

	<i>Never</i>	<i>Sometimes</i>	<i>Often</i>
<i>I have racing thoughts through my mind</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>I feel unable to move</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>I have creeping, crawling, aching/twitching feeling in my legs (feels like I have to constantly move them</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>I have vivid, dream-like scenes even though I know I am not totally asleep</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>I experience pain or discomfort while/during sleep</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>I feel afraid of the dark or something else</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>I suddenly become aware or alert</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>I feel afraid I wont return to sleep after awakening</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>I sleep with someone else in my bed/in my room</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>I have restless, disturbed sleep</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>I get up at night to attend to my children or something else</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>I snore loudly</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>I feel my heart pounding or palpating during the night</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>I sweat a lot during the night</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>I walk in my sleep</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>I fall out of bed while asleep</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>I wake up screaming, violent or confused</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>I have unusual movements while asleep</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>I wet my bed</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

I have dreams *Never* *Sometimes* *Often*

I grind my teeth

On average how many hours of sleep do you get each night? _____hours, _____minutes

How many times do you usually awaken each night? _____ Do you have trouble getting back to sleep? Yes No

On a typical night, what is your longest period of wakefulness? ____Hours, ____Minutes

How long are you awake all together during the night? _____Hours, _____Minutes

If you awaken during the night, is it usually during the: *1st half of the night*
 2nd half of the night

My sleep is frequently disturbed by: (Check all that are true)

- | | | | | |
|--|--|---|--|--|
| <input type="checkbox"/> <i>heat</i> | <input type="checkbox"/> <i>cold</i> | <input type="checkbox"/> <i>light</i> | <input type="checkbox"/> <i>noise</i> | <input type="checkbox"/> <i>noise or movement of bed partner</i> |
| <input type="checkbox"/> <i>asthma</i> | <input type="checkbox"/> <i>cough</i> | <input type="checkbox"/> <i>shortness of breath</i> | <input type="checkbox"/> <i>choking</i> | <input type="checkbox"/> <i>indigestion, "gas" or heartburn</i> |
| <input type="checkbox"/> <i>hunger</i> | <input type="checkbox"/> <i>thirst</i> | <input type="checkbox"/> <i>need to urinate</i> | <input type="checkbox"/> <i>chest pain</i> | <input type="checkbox"/> <i>frightening dreams</i> |

About Waking

What time do you usually have your final awakening? _____am/pm

What time do you usually get out of bed after your final awakening? _____am/pm

How much does your final awakening time vary? From: _____am/pm To: _____am/pm

Check One box For Each Statement

	<i>Never</i>	<i>Sometimes</i>	<i>Often</i>
<i>I depend on an alarm clock to wake me up</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>I “sleep-in” in the morning (more than 1 hour) past my usual wake up time</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>I have a very hard time waking up</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>I have vivid dream-like images when waking up even though I know I am not asleep</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>I wake up confused or disoriented</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>I wake up with a headache</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>I wake up nauseous (sick to my stomach)</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>I wake up with a dry mouth</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>I wake up 1 to 2 hours before I have to get up</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

About Daytime Functioning

How many naps do you take in a usual week? _____

Are the naps refreshing? Yes No

Check One Box For Each Statement

	<i>Never</i>	<i>Sometimes</i>	<i>Often</i>
<i>I feel sleepy during the day</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>I fall asleep unintentionally. Please give an example:</i> _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>I have thoughts racing through my mind</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>I feel sad or depressed</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>I have anxiety (worry about things)</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>I feel sleep while driving or have been in a motor vehicle accident</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>