



# Pulmonary & Sleep Consultants, LLC

## Serenity Sleep Institute



Patient name \_\_\_\_\_ DOB: \_\_\_\_\_

Referral doctor: \_\_\_\_\_

Date of Service \_\_\_\_\_

Reason for visit: \_\_\_\_\_

Weight \_\_\_\_\_ Height \_\_\_\_\_ BMI \_\_\_\_\_ Neck Size \_\_\_\_\_ BP \_\_\_\_\_/\_\_\_\_ HR \_\_\_\_\_ Temp \_\_\_\_\_

RR \_\_\_\_\_ O2 Sat \_\_\_\_\_ % FiO2 \_\_\_\_\_

Please Circle Yes or No	DOCTOR'S COMMENTS
Asthma <span style="margin-left: 100px;">Y</span> <span style="margin-left: 20px;">N</span>	<input type="checkbox"/> Exac last 12 months
COPD <span style="margin-left: 100px;">Y</span> <span style="margin-left: 20px;">N</span>	<input type="checkbox"/> Hosp last 12 months
Lung Cancer <span style="margin-left: 100px;">Y</span> <span style="margin-left: 20px;">N</span>	<input type="checkbox"/> Intubation
Use Oxygen <span style="margin-left: 100px;">Y</span> <span style="margin-left: 20px;">N</span>	Night <input type="checkbox"/> liter/minute
	Rest <input type="checkbox"/> liter/minute
	Exercise <input type="checkbox"/> liter/minute
Shortness of Breath <span style="margin-left: 100px;">Y</span> <span style="margin-left: 20px;">N</span>	<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe exertion
	When did it start _____
	Patient can walk <input type="checkbox"/> minutes on level ground.
	<input type="checkbox"/> walking up an incline
	<input type="checkbox"/> walking upstairs
Cough <span style="margin-left: 100px;">Y</span> <span style="margin-left: 20px;">N</span>	It started _____
	<input type="checkbox"/> Productive <input type="checkbox"/> Not Productive
	Aggravating factors _____
	Alleviating factors _____
Chest Pain <span style="margin-left: 100px;">Y</span> <span style="margin-left: 20px;">N</span>	
Wheezing <span style="margin-left: 100px;">Y</span> <span style="margin-left: 20px;">N</span>	
Cough up blood (hemoptysis) <span style="margin-left: 100px;">Y</span> <span style="margin-left: 20px;">N</span>	
	LDCT _____
	BeLPT _____

Name \_\_\_\_\_ DOB \_\_\_\_\_ Date of Service \_\_\_\_\_

<b>SLEEP HISTORY</b>		
Bedtime		AM / PM
Out of Bed		AM / PM
Shiftwork	Y	N
<b>Please circle YES or NO</b>		
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
Wake up during sleep	Y	N
How many times?		
Why?		
Daytime naps	Y	N
How many naps?		
How long is each nap?		
Insomnia (difficulty sleeping)	Y	N
<p>OSA;CSA</p> <p>Location: _____ Date: _____</p>          <p>CPAP/AUTO CPAP/BiPAP Y N _____cm H<sub>2</sub>O</p> <p>Patient has had current CPAP/BiPAP machine since _____</p> <p>DME: _____</p>		

<b>DOCTOR'S COMMENTS:</b>		
Cataplexy	Y	N
HGH	Y	N
HPH	Y	N
Sleep Paralysis	Y	N
RLS	Y	N
Sleep Walking	Y	N
ESS		
<p>Sleep onset</p> <p>Sleep maintenance</p> <p>Treated</p>		

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**Review of Systems: Please answer YES only to symptoms significant to today's visit**

GENERAL			GENITOURINARY		
Fatigue	Y	N	Painful urination	Y	N
Weight loss	Y	N	Blood in urine	Y	N
Weight gain	Y	N	Penile discharge (male)	Y	N
Night sweats	Y	N	Frequent urination	Y	N
Fever	Y	N	Urinary incontinence	Y	N
Chills	Y	N	<b>OB/GYN</b>		
<b>EYES</b>			Vaginal discharge	Y	N
Double vision	Y	N	Vaginal bleeding	Y	N
Blurred vision	Y	N	Breast Lump	Y	N
Decreased vision	Y	N	Breast pain	Y	N
Itchy eyes	Y	N	Breast discharge	Y	N
Eye pain	Y	N	<b>ENDOCRINE</b>		
<b>EAR, NOSE &amp; THROAT</b>			Hot intolerance	Y	N
Decreased hearing	Y	N	Cold intolerance	Y	N
Ringing in the ears	Y	N	Excessive urination	Y	N
Ear pain	Y	N	Excessive thirst	Y	N
Ear discharge	Y	N	<b>MUSCULOSKELETAL</b>		
Hoarseness	Y	N	Joint pain	Y	N
Nasal bleeding	Y	N	Joint swelling	Y	N
Nasal discharge	Y	N	Joint redness	Y	N
Difficulty swallowing	Y	N	<b>CARDIOVASCULAR</b>		
Painful swallowing	Y	N	Palpitation	Y	N
<b>ALLERGIC RHINITIS</b>			Leg swelling (edema)	Y	N
Runny nose	Y	N	Leg pain with walking	Y	N
Post-nasal drip	Y	N	Can NOT sleep flat	Y	N
Sneezing	Y	N	Wake up short of breath	Y	N
Nasal congestion	Y	N	<b>NEUROLOGIC</b>		
<b>DIGESTIVE</b>			Tremors	Y	N
Nausea	Y	N	Muscle weakness	Y	N
Vomiting	Y	N	Headache	Y	N
Heartburn	Y	N	Numbness	Y	N
Diarrhea	Y	N	<b>SKIN</b>		
Constipation	Y	N	Itching	Y	N
Blood in stool	Y	N	Rash	Y	N
Black tarry stool	Y	N	Hair loss	Y	N
Jaundice	Y	N	Nail changes	Y	N
Abdominal pain	Y	N			
<b>HEMATOLOGIC/LYMPHATIC</b>					
Swollen Lymph nodes	Y	N			
Bleeding	Y	N			
Bruising	Y	N			
<b>PSYCHIATRIC</b>					
Anxiety	Y	N			
Depression	Y	N			
Suicidal thoughts	Y	N			

**Past Medical and Surgical History**

Psychiatric			Hematologic/Cancers		
Anxiety	Y	N	Leukemia	Y	N
Depression	Y	N	Lymphoma	Y	N
Bipolar disorder	Y	N	Bleeding Disorder	Y	N
Post-Traumatic Stress Disorder	Y	N	Anemia	Y	N
Schizophrenia	Y	N	Blood Clots in Legs/Arms (DVT)	Y	N
Neurologic			Breast Cancer	Y	N
Dementia	Y	N	Lung Cancer	Y	N
Stroke	Y	N	Colon Cancer	Y	N
TIA (Mini stroke)	Y	N	Kidney Cancer	Y	N
Seizure	Y	N	Prostate Cancer	Y	N
Parkinson's	Y	N	Bladder Cancer	Y	N
Peripheral Neuropathy	Y	N	Other Cancer:		
Migraine	Y	N	Endocrine		
Nose/Sinuses			Diabetes	Y	N
Chronic sinus infection	Y	N	Hypothyroidism	Y	N
Allergies (nose & sinuses)	Y	N	Grave's Disease	Y	N
Non-Allergic rhinitis	Y	N	High Cholesterol/lipids	Y	N
Lung			Rheumatology		
COPD	Y	N	Rheumatoid arthritis	Y	N
Tuberculosis	Y	N	Lupus (SLE)	Y	N
Bronchiectasis	Y	N	Scleroderma	Y	N
Lung fibrosis	Y	N	Fibromyalgia	Y	N
Asbestosis	Y	N	Surgeries		
Asthma	Y	N	Heart Stents	Y	N
Pulmonary Embolism	Y	N	CABG (Bypass surgery)	Y	N
Pleural Effusion	Y	N	Heart Valve Replacement	Y	N
Sleep			Metallic Heart Valve	Y	N
Sleep Apnea	Y	N	Aneurysm repair ((Abd) (Thor)	Y	N
Insomnia	Y	N	Stents in legs	Y	N
Restless Legs Syndrome	Y	N	Pacemaker placement	Y	N
Narcolepsy	Y	N	Defibrillator placement	Y	N
Heart			Sinus Surgery	Y	N
CAD (blockage in the 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 (P. Afib)	Y	N	Gallbladder surgery	Y	N
High blood pressure	Y	N	Appendectomy	Y	N
Gastrointestinal			Hysterectomy (Partial) (Complete)	Y	N
Heartburn (Reflux) (GERD)	Y	N	Cataract surgery	Y	N
Hiatal Hernia	Y	N	Hernia Surgery	Y	N
Stomach ulcer	Y	N	Joint replacement	Y	N
Ulcerative colitis	Y	N	Joint Surgery	Y	N
Crohn's disease	Y	N	Spinal Surgery (Cervical) (Lumbar)	Y	N
Hepatitis A B C	Y	N	Other Surgeries:		
Cirrhosis	Y	N			
Fatty Liver (NASH)	Y	N			
Nephrology/Urology					
Kidney Stones	Y	N			
Dialysis	Y	N			
BPH (large prostate)	Y	N			

Name \_\_\_\_\_ DOB \_\_\_\_\_ Date of Service \_\_\_\_\_

Current Job \_\_\_\_\_ Previous Job \_\_\_\_\_

**Marital Status:** Married Single Divorced Widow Separated Other

**Smoking**

€ Never

€ Current Smoke up to \_\_\_\_\_ packs/day Number of years \_\_\_\_\_

€ Quit When \_\_\_\_\_ packs/day Number of years \_\_\_\_\_

**Exposure**

Second-hand smoke Y N

Asbestos Y N

Beryllium Y N

Pulmonary irritant chemicals Y N

Tuberculosis (TB) Y N

Pets Y N What \_\_\_\_\_

Birds Y N What \_\_\_\_\_

Hot Tub (NOT Jacuzzi) Y N

Alcohol Y N Amount \_\_\_\_\_ Frequency \_\_\_\_\_

Coffee or caffeine containing beverages Y N Amount \_\_\_\_\_ Frequency \_\_\_\_\_

Do you use illegal drugs? Y N What \_\_\_\_\_

Did you use illegal drugs in the past? Y N What \_\_\_\_\_

Recent travel in the last few months? Y N Where \_\_\_\_\_ When \_\_\_\_\_

**Family History:**

Father: Alive Deceased Age \_\_\_\_\_ Diseases \_\_\_\_\_

Mother: Alive Deceased Age \_\_\_\_\_ Diseases \_\_\_\_\_