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		
Asthma	Y	N
COPD	Y	N
Lung Cancer	Y	N
Use Oxygen	Y	N
Shortness of Breath	Y	N
Cough	Y	N
Chest Pain	Y	N
Wheezing	Y	N
Cough up blood (hemoptysis)	Y	N

DOCTOR'S COMMENTS

____ Exac last 12 months
____ Hosp last 12 months
____ Intubation

Night ____ liter/minute
Rest ____ liter/minute
Exercise ____ liter/minute

____Mild ____Moderate ____Severe exertion
When did it start _____
Patient can walk ____ minutes on level ground.
_____walking up an incline
_____ walking upstairs

It started _____
_____Productive ___ Not Productive
Aggravating factors _____
Alleviating factors _____

LDCT_____

BeLPT _____

Name _____DOB_____Date of Service_____

SLEEP HISTORY

Bedtime		AM / PM	
Out of Bed		AM / PM	
Shiftwork		Y	N
Please circle YES or NO			
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

OSA;CSA

Location: _____ Date: _____

CPAP/AUTO CPAP/BiPAP Y N _____cm H_2O

Patient has had current CPAP/BiPAP machine since_____

DME: _____

DOCTOR'S COMMENTS:

Cataplexy	Y	N
HGH	Y	N
HPH	Y	N
Sleep Paralysis	Y	N
RLS	Y	N
Sleep Walking	Y	N
ESS		

Sleep onset
Sleep maintenance
Treated

Name_____ **DOB**_____ **Date of Service** _____

Review of Systems: Please answer YES only to symptoms <u>significant to today's visit</u>

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	**OB/GYN**		
EYES			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	**ENDOCRINE**		
EAR, NOSE & THROAT			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	**MUSCULOSKELETAL**		
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	**CARDIOVASCULAR**		
Painful swallowing	Y	N	Palpitation	Y	N
ALLERGIC RHINITIS			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	**NEUROLOGIC**		
DIGESTIVE			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	**SKIN**		
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			
HEMATOLOGIC/LYMPHATIC					
Swollen Lymph nodes	Y	N			
Bleeding	Y	N			
Bruising	Y	N			
PSYCHIATRIC					
Anxiety	Y	N			
Depression	Y	N			
Suicidal thoughts	Y	N			

Name_____ **DOB**_____ **Date of Service**_____

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 _____