DESERT CENTER FOR ALLERGY AND CHEST DISEASES

Pulmonary Medicine, Allergy/Immunology, Sleep Disorders

Pulmonary Rehabilitation, Pulmonary Function Laboratory

HEALTH QUESTIONAIRE

NAME_____

What is your presenting problem?

_____

_____

How long has it been going on?

_____

PAST MEDICAL PROBLEMS- Check mark if you have any of the following

Heart problems	_____	**Liver problems**	_____
Stroke	_____	**Arthritis**	_____
Emphysema	_____	**Glaucoma**	_____
Bronchitis	_____	**Brittle bones**	_____
Asthma	_____	**Cancer**	_____
Stomach ulcers	_____	**High Blood pressure**	_____
Thyroid disease	_____	**Diabetes**	_____

Major surgeries?

_____

_____

Allergies to any medications?

_____

List of medications?

_____

_____

SOCIAL HISTORY

Have you ever smoked? _____ What age did you begin? _____

How many packs a day? _____ Are you currently a smoker? _____

How often do you drink alcohol? _____ How many? _____

Are you married? _____ How long? _____

Is someone living with you? _____ How long? _____

Do you have any children? _____ How many? _____

Do they live in Arizona? _____

How long have you lived in Arizona? _____

What kind of work do/did you do? _____

What is your spouse's occupation? _____

Do you have pets? _____ What kind? _____

Have you traveled in the past year outside of the southwest? _____

Where? _____

FAMILY HISTORY

What illnesses are seen in your family?

Asthma, Emphysema, Cancer, Tuberculosis, Heart Disease or Heart Attacks, High Blood Pressure, Strokes, or Diabetes.

Father:

_____

_____

Mother:

_____

_____

Siblings:

_____

_____

Children:

_____

_____

REVIEW OF SYSTEMS

Have you had any fever or illnesses in the past 6 months? _____

How is your appetite? _____ Any recent changes? _____

Has your weight changed in the last 6 months? _____

Do you have any rashes? _____

Any recent changes in vision? _____

Do you have difficulty hearing? _____

Do you have postnasal drip? _____

Do you have a history of sinus problems? _____

Do you have neck or pain lumps? _____

Do you have a history of Valley Fever? _____

Have you ever been tested for Tuberculosis? Is so, where and when?

_____

Do you have chest pain or pressure with exertion? _____

Have you had any fainting spells? _____

Do your legs swell? _____

Do you get heart burn? _____

Has there been a recent change in bowel habits? _____

Do you have any pain or blood with urination? _____

Do you have urinary incontinence? _____

Do you have redness, swelling or warmth of your joints? _____

Do you have new or recent headaches? _____

DAYTIME SLEEPINESS

	YES	NO
Are you usually sleepy during the day?	_____	_____
Do you usually have trouble staying awake during the day?	_____	_____
Have you ever fallen asleep at an inappropriate time like (talking, eating, working, or driving)?	_____	_____

SLEEP SYSTEMS

Does your mate sleep in the same room (due to sleep habits)?	_____	_____
Have you been told you stop breathing during sleep?	_____	_____
Are you a violent sleeper (thrash around, throw off sheets)?	_____	_____
Do you grind your teeth at night?	_____	_____
Do you awaken with headaches in the a.m.?	_____	_____
Do you awaken with chest pain?	_____	_____
Do you awaken with shortness of breath?	_____	_____
Do you experience fogginess or incoordination upon wakening?	_____	_____
Sinus problems?	_____	_____
Family history of snoring/disturbed sleep?	_____	_____

NARCOPLEPSY SYMPTOMS

Persistent, uncontrollable sleep attacks?	_____	_____
Automatic behavior? (Perform routine activities without remembering)	_____	_____
Hypnagogic hallucination? (Vivid hallucination while falling asleep)	_____	_____
Sleep paralysis? (Inability to move while Partially awake)	_____	_____

Surgery on tonsils_____ Adenoids _____ Deviated septum _____
Broken nose _____ Obstruction ____

Comments:

_____

_____

Epworth Sleepiness Scale

Rate the chance that you will doze off or fall asleep during the following routine daytime situations.

0- Would never doze
1- Slight chance of dozing
2- Moderate chance of dozing
3- High chance of dozing

Sitting and reading	
Watching T.V.	
Sitting inactive in a public place (Ex. Theater or meeting)	
As a passenger in a car for an hour without a break.	
Lying down to rest in the afternoon	
Sitting and talking to someone	
In a car, while stopped in traffic	
Sitting quietly after lunch (When you've had no alcohol)	