Name: _____

Date of Birth: _____

Date: _____

DuPage Medical Group

WE CARE FOR YOU

Pulmonary Medicine • Critical Care • Sleep Medicine

Patient Questionnaire

Age: _____ Sex: _____ Height: _____ Weight: _____ Neck Size: _____

What is the name of the doctor who referred you here today? _____

1. Briefly describe your complaint: _____

_____

2. How long have you had this problem? _____
3. List all MEDICAL and PSYCHIATRIC problems for which you have been or are currently being treated: _____

_____

_____

4. List all past SURGICAL procedures _____

_____

_____

5. List all prescriptions and over the counter medications you are taking:

Medication	Strength/Dose	Medication	Strength/Dose

6. Are you allergic to any medications? Please list _____

_____

Social History

7. How many caffeinated beverages do you drink per day? _____ Per week? _____
8. How many alcoholic beverages do you drink per day? _____ Per week? _____
9. Have you ever smoked? □ Yes □ No

If so, how much tobacco did you use? _____ For how many years? _____ How long ago did you quit? ____

10. Have you ever used illegal drugs? □ Yes □ No If so, what type _____
11. Have you had a significant weight loss recently? □ Yes □ No Significant weight gain recently? □ Yes □ No
    Number of lbs? _____
12. How far can you walk without becoming short of breath? _____
13. What is Your Current Occupation? _____
14. Are You Exposed to Fumes/Dust? _____
16. Any Recent Travel _____
17. Any Pets _____
18. □ Married □ Divorced □ Single □ Widow How many children? _____ Ages _____

Family Medical History

19. Please provide information about the ***medical problems*** of your relatives:

Father _____ Mother _____ Sibling(s) _____

REVIEW OF SYSTEMS

Y	N		Y	N	
		Fever or chills			Bone, muscle or joint problems
		Weight loss			Depression, anxiety or mental illness
		Sweats			Skin conditions, growths or cancers
		Fatigue			Allergy or immune problems
		Visual problems			Kidney, bladder or urination problems
		Asthma, breathing or lung problems			Sexual, gynecologic, or testicular problems
		Chest pain			Seizure
		Heart problems (heart attack, pacemaker…)			Thyroid, endocrine or hormone disorders
		Stroke or headache problems			Tuberculosis or infectious disease
		Blood pressure or circulation problems			HIV or AIDS
		Blood or lymph nodes diseases			Hepatitis A, B or C
		Excessive or abnormal bleeding			Excessive scarring
		Stomach or digestive problems (ulcer, heartburn …)			Recent dental work
		Sleep or snoring problems			Do you have any other conditions or problems

Review of systems otherwise negative □

Please explain if you answered yes to any of the above: _____

_____

_____

SLEEP HISTORY

What is your usual bedtime? _____AM/PM

What is your usual wake time? _____ AM/PM

How long does it usually take you to fall asleep? _____ hours _____minutes

How many times do you wake up during the night? _____

Do you usually feel refreshed when you wake up in the morning? □ Yes □ No

Do you take PLANNED naps? □ NEVER □ DAILY □ WEEKLY □ OCCASIONALLY

Do you DOZE OFF UNINTENTIONALLY? □ NEVER □ DAILY □ WEEKLY □ OCCASIONALLY

Just prior to falling asleep or upon awakening, do you experience cramping, aching leg feeling or inability to keep your legs still? □ Yes □ No

Do you experience leg jerks while you are asleep? □ Yes □ No

Do you snore? □ Yes □ No

EPWORTH SCALE

How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired? This refers to your usual way of life in recent times. Even if you have not done some of these things during the past week, estimate how likely you would be to doze off or fall asleep in these situations. Use the following scale:

0 = would **NEVER** doze
1 = **SLIGHT** chance of dozing
2 = **MODERATE** chance of dozing
3 = **HIGH** chance of dozing

Situation	**Chance of Dozing**
a) Sitting and reading	_____
b) Watching TV	_____
c) Sitting, inactive in a public place (e.g., a theater or a meeting)	_____
d) As a passenger in a car for an hour without a break	_____
e) Lying down to rest in the afternoon when circumstances permit	_____
f) Sitting and talking to someone	_____
g) Sitting quietly after a lunch without alcohol	_____
h) In a car, while stopped for a few minutes in traffic	_____
Total	_____

Completed by: (Patient Signature) _____

Physician Signature: _____