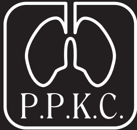

Pulmonary Physicians of Kansas City, Inc.

816-389-6100

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Welcome to Pulmonary Physicians of Kansas City, Inc. In order to insure your best care, it is important that you take the time to complete this medical questionnaire thoroughly. Please list your name and today's date in the space provided at the top of each page .

Name_______________________________________ Date of Birth ____/____/____

Who referred you?____

Sleep Assessment Questionnaire: (Please circle Y for Yes or N for No.)

What is your sleep problem? ____________________
____

How long have you had this problem? ______________

Y / N Is it getting worse?

How many nights a week do you have difficulty sleeping? _____

Y / N Do you take naps?

Y / N Do you have a bedpartner?

What time do you usually go to bed? ______________

How long does it take you to fall asleep? ____________

Y / N Do you experience a creepy-crawling sensation when you go to sleep?

Y / N Have you ever been told you kick your legs at night?

Y / N Do you snore?

Y / N Have you been told that you quit breathing when you are asleep?

Y / N Are you a restless sleeper?

Y / N Do you dream?

Y / N Do you have nightmares?

Y / N Do you recall your dreams/nightmares?

How many times do you wake up each night? ________

What do you think wakes you up? _______________
____

Y / N Have you found that you act out your dreams at night?

Y / N Do you ever wake up and feel that you are unable to move?

Y / N Do you wake up gasping or choking at night?

Y / N Do you hallucinate when falling asleep or waking up?

Y / N Have you ever experienced sleepwalking?
If yes, please describe: ____________________
____

Y / N Have you ever had problems with wetting the bed?
If yes, please describe: ________________________
____

Y / N Do you wake up in the early morning?
If so, what do you think wakes you? __________
____

How many hours of sleep do you usually get a night? _____

What time do you usually get out of bed? ___________

Y / N Do you usually wake up feeling refreshed?

Y / N Do you have morning headaches?

Y / N Do you experience excessive daytime sleepiness?

Do you fall asleep when...

Y / N ...reading the paper?
Y / N ...watching TV?
Y / N ...talking to someone boring?

Y / N Do you have a different sleep schedule on weekends?
If yes, please describe: ____________________
____

Y / N Do you sleep better away from home or on vacation?
If yes, please describe: ____________________
____

Y / N Have you every used a sleep aid?
If yes, what kind and how often? ____________
____

Y / N Have you ever used prescription pills for sleep?
If yes, which ones? ____________________
When did you use them ____________________
Did they help? Y / N

Y / N Have you ever had problems falling asleep or staying asleep besides those described above?
If yes, please describe: __________________

☐ Please check here and use back side if you need more space

Name____ Date of Birth ____/____/____

Past Medical History:

Surgery:

Name of Surgery	Year	Surgeon	Hospital

☐ If you need more room, check this box and add additional notes on page 4.

Hospitalization:

Year	Reason	Hospital

☐ If you need more room, check this box and add additional notes on page 4.

Past Illnesses: *(Please check any illnesses you've had)*

____ Rheumatic Fever
____ Scarlet Fever
____ Heart Attack
____ High Blood Pressure
____ Diabetes
____ Tuberculosis
____ Pneumonia
____ Asthma
____ Allergies
____ Emphysema
____ Hay Fever
____ Kidney Disease
____ Liver Disease
____ Gallbladder
____ Anemia
____ Whooping Cough
____ Cancer
____ Bronchitis
____ Other: __________
____

When was your last TB skin test? ___________

Immunizations: *(Please check all that you've had and list the year in which you had it.)*

____ Tetanus (Year)____
____ Hepatitis (Year)____
____ Pneumonia (Year)____
____ Chicken Pox (Year)____
____ Flu (Year)____
____ MMR (Year)____

Have you had a blood transfusion? Y / N

If so, when? ______________________________

____

Medications:

Please list your current medications: *(include any INHALERS and/or over-the-counter such as Vitamins)*

Medication	Strength	Frequency

☐ If you need more room, check this box and add additional notes on page 4, or ask for supplemental medication list.

Allergies to Medications:

Please list any allergies to medications:

Medication	Type of Reaction

☐ If you need more room, check this box and add additional notes on page 4.

(Please continue filling out this form on the attached paper...)

Name______________________________ Date of Birth ____/____/____

Social History:

History of tobacco use:

Do you smoke cigarettes/cigars? Y / N

If so, how many per day? ______________

How many years have you smoked? ______________

If you used to smoke, how long ago did you quit? ______

History of Alcohol Use:

Do you consume alcohol? Y / N

If so, how many drinks per week? ______________

Caffeine Use:

Do you consume caffeine? Y / N

If so, how many drinks per day? ______________

Illicit Drug Use:

Do you use illegal drugs? Y / N

If so, what type and how often? ______________

____

Marital Status: (circle one)

Single / Married / Divorced / Widowed

Children:

Number of children: ______________

Any Medical problems? ______________

____

Environmental History:

Have you ever been exposed to any harmful substances?

Name of Harmful Substance	# of years

☐ If you need more room, check this box and add additional notes on page 4.

Occupational Information:

List all occupations and how long you worked at each:

Occupation	# of Years

☐ If you need more room, check this box and add additional notes on page 4.

Family History

Family Member	Living	Deceased	Age/Age at death	Health Condition or Cause of Death
Father				
Mother				
Spouse				

Siblings	Age/Age at death	Current Health Condition or Cause of Death

☐ If you need more room, check this box and add additional notes on page 4.

Check any diseases that a blood relative may have had:

______ Heart Disease

______ Allergies

______ High Blood Pressure

______ Nervous Illness

______ Thyroid Disease

______ TB

______ Cancer

______ Diabetes

______ Congenital Disease

Other: ______________

____

____

(Please continue filling out this form on the attached paper...)

Name____ Date of Birth ____/____/____

System Review: (Please check all that apply.)

ENT:
______ Difficulty hearing
______ Earache
______ Noises in ears
______ Nasal stuffiness
______ Nosebleeds
______ Presistent hoarseness
______ Sore or bleeding gums
______ Sore tongue
______ Frequent head colds

Eyes:
______ Wear glasses
______ Impaired vision
______ Irritation of eyes
______ Watering of eyes

Respiratory:
______ Shortness of breath
______ Wheezing
______ Raise phlegm
______ Cough up blood
______ Daily cough

Cardiac:
______ Chest pain
______ Irregular heartbeat
______ High blood pressure
______ Leg swelling

Gastrointestinal:
______ Poor appetite
______ Trouble swallowing
______ Nausea or vomiting
______ Indigestion
______ Heartburn
______ Abdominal pain or distress
______ Gas or bloating
______ Constipation
______ Blood in stools
______ Diarrhea or dysentery

Genitourinary:
______ Getting up more than once a night to urinate
______ Trouble starting stream
______ Trouble emptying bladder
______ Blood in urine

Gynecological: (Females Only)
______ Menopause
______ Hormonal replacement
______ Birth control pills

Neurological:
______ Bad headaches
______ Blackout spells
______ Convulsions
______ Paralysis
______ Numbness of hands
______ Numbness of feet
______ Musculoskelatal
______ Frequent back pain
______ Rheumatism or arthritis
______ Localized weakness
______ General weakness

Psychiatric:
______ Nervous or upset
______ Feeling depressed
______ Difficulty with sex life

Endocrine:
______ Hormonal problems
______ Heart palpitations
______ Bulging eyes

Integumentary:
______ Sebaceous cysts
______ Skin cancer
______ Lumps in breasts
______ Breast cancer

Immune system:
______ Multiple infections
______ Immune deficiency
______ Seasonal allergies

General:
______ Fatigue
______ Fever or sweats
______ Weight loss, Amount:
______ Weight gain, Amount:

Additional Notes for the Doctor: