Adult New Patient Medical Background Information

PATIENT INFORMATION

Patient Name: Date of Birth: / /

Chief Complaint:

MEDICATIONS (including prescription and over-the-counter)

1.
2.
3.
4.
5.
6.

Do you have any allergies to any medications? Yes No

If yes -please list:

PAST SURGICAL HISTORY

Have you ever had your tonsils and/or adenoids surgically removed? Yes No

SOCIAL HISTORY

Caffeine:

# of cups of coffee per day

# of cups of tea per day

cans or glasses of soda per day

of servings of chocolate per week

# of energy drinks per day

Alcohol: **None** **Yes** # of drinks per day # of drinks per week # of drinks per month

Tobacco: **None** **Yes** # of packs per day # of years

Recreational Drugs (such as marijuana or cocaine): None Yes

If yes, which ones?

Marital Status: Married Single Divorced Widowed

Children: No Yes How many?

Pets: Yes No How many? What type of pet?

Do you have any children or pets that sleep in your bedroom? No Yes

REVIEW OF SYMPTOMS

CONSTITUTIONAL

Loss of Appetite:	Yes	No
Sweats:	Yes	No
Fever:	Yes	No
Fatigue:	Yes	No
Weight Gain:	Yes	No
Weight Loss:		

RESPIRATORY

Cough:	Yes	No
Asthma:	Yes	No
Wheezing:	Yes	No
Poor Exercise Tolerance:	Yes	No

GASTROINTESTINAL

GERO/Heartburn/Indigestion:	Yes	No
Black or Bloody Stools:	Yes	No
Diarrhea:	Yes	No
Nausea/Vomiting:	Yes	No
Jaundice:	Yes	No
Abdominal Pain:	Yes	No

No

GENITOURINARY

Bed Wetting:	Yes	No
Frequent Urination:	Yes	No
Difficulty Urinating:	Yes	No
Blood in Urine:	Yes	No
Erectile Dysfunction:	Yes	No

ALLERGY/IMMUNOLOGY

Sneezing:	Yes	No
Runny Nose:	Yes	No
Itchy Eyes or Nose:	Yes	No
Hives:	Yes	No
Nasal allergies/Hay fever	Yes	No
Nasal Congestion	Yes	No

EYES

Blurry Vision:	Yes	No
Double Vision:	Yes	No
Vision Loss:	Yes	No

CARDIAC

Palpitations:	Yes	No
Chest Pain:	Yes	No
Daytime Shortness of Breath:	Yes	No
Nighttime Shortness of Breath:	Yes	No
Ankle Swelling:	Yes	No

SKIN

Unusual Moles:	Yes	No
Rash:	Yes	No
Dryness:	Yes	No

ENDOCRINE

Heat Intolerance:	Yes	No
Excessive Thirst:	Yes	No
Constipation:	Yes	No
Cold Intolerance:	Yes	No
Cold Hands/Feet:	Yes	No
Decreased Libido:	Yes	No

MUSCULOSKETETAL:

Stiff/Sore Joints:	Yes	No
Muscle Pain:	Yes	No
Red or Swollen Joints:	Yes	No
TMJ pain/jaw discomfort:	Yes	No
Ears/Nose/Throat/	Yes	No
Mouth: Hearing Loss: Sore	Yes	No
Throat: Sinus Congestion:	Yes	No
Hoarseness:	Yes	No

NEUROLOGICAL

Weakness:	Yes	No
Seizures:	Yes	No
Involuntary Tongue	Yes	No
Biting: Passing Out:	Yes	No
Dizziness:	Yes	No
Headaches:	Yes	No
Numbness:	Yes	No
Restless Leg Syndrome:		

PSYCH

Excessive Stress:	Yes	No
Memory Loss:	Yes	No
Difficulty with Focus:	Yes	No
Trouble Concentrating:	Yes	No
Hallucinations:	Yes	No
Nervousness or Anxiety:	Yes	No
Depressed Mood:	Yes	No

Ears/Nose/Throat/Mouth:

Hearing Loss:	Yes	No
Sore throat:	Yes	No
Sinus Congestion:	Yes	No
Hoarseness:	Yes	No
Tubes in Ear	Yes	No

FAMILY HISTORY

Do you have a family history of any of the following medical illnesses? (Check if "yes" to all that apply):

High blood pressure/ hypertension
Heart disease
stroke
Congestive heart failure
Depression
Diabetes
Overweight/obesity
Snoring
Sleep apnea
Anxiety
Chronic insomnia
Restless Legs Syndrome
Multiple Sclerosis
Sleep walking

Was your child breast fed?

If your child was breast fed - for how long?

Was your child Full Term Premature

If premature - at how many weeks was your child delivered?

Adult Sleep & Breathing Questionnaire

Date:

Patient's Name:

Patient's Date of Birth: / / Age:

Male Female

Have you ever had a sleep test administered? yes no

If yes - when did you have your last sleep test?

Have you been diagnosed with Sleep Apnea? yes no

Do you currently use a CPAP or Sleep Appliance for Sleep Apnea? yes no

Are you happy with your CPAP or Sleep Appliance? yes no

If not happy - why?

	Yes	No
How often do you get out of bed to use the restroom during the night?		
Do you usually wake feeling tired and unrested?		
Do you habitually snore?		
Have you been diagnosed with Hypertension/High Blood Pressure?		
Do you often suffer from waking headaches?		
Do you regularly experience daytime drowsiness or fatigue?		
Do you have blocked nasal passages?		
Has anyone observed you stop breathing during your sleep?		
Do you ever wake up choking or gasping?		
Do you grind your teeth while sleeping?		
Is your neck circumference greater than 40 cm/ 15.75"?		

Is your Body Mass Index (BMI) more than 35?

BMI Formula BMI = (your weight in pounds X 703) / (your height in inches X your height in inches

The Epworth Sleepiness Scale

How likely are you to doze off or fall asleep in the following situations, iin contrast to feeling just tired? This refers to your usual way of life in recent times. Even if you have not done some of these things recently, try to work out how they would have effected you. Use the following scale to choose the most appropriate number for each situation.

0 = no chance of dozing
1 = slight chance of dozing
2 = moderate chance of dozing
3 = high chance of dozing

SITUATION	CHANCE OF DOZING
Sitting and reading	
Watching TV	
Sitting inactive in public place (like a theater or a meeting)	
As a passenger in a car for an hour without a break	
Lying down to rest in the afternoon when circumstances permit	
Sitting and talking to someone	
Sitting quietly after a lunch without alcohol	
In a car, while stopped for a few minutes in traffic	
TOTAL SCORE	

Analyze Your Score

Interpretation:

From 0-7	It is unlikely that you are abnormally sleepy
From 8-9	You have an average amount of daytime sleepiness
From 10-15	You may be excessively sleepy, depending on the situation. You may want to consider seeking medical attention
From 16-20	You are excessively sleep and should consider seeking medical attention

BERLIN QUESTIONNAIRE©

Height (m) Weight (kg) Age Male Female

Please choose the correct response to each question.

CATEGORY 1

1. Do you snore?

Yes

No

I don't know

If you snore:

2. Your snoring is:

a. Slightly louder than breathing
b. As loud as talking
c. Louder than talking
d. Very loud - heard in adjacent rooms

2. How often do you snore

a. Nearly every day
b. 3-4 times a week
c. 1-2 times a week
d. 1-2 times a month
e. Never or nearly never

3. Has your snoring ever bothered other people?

a. Yes
b. No
c. I don't know

5. Has anyone noticed that you quit breathing during your sleep?

a. Nearly every day
b. .3-4 times a week
c. 1-2 times a week
d. 1-2 times a month
e. Never or nearly never

CATEGORY 2

6. How often do you feel tired or fatigued after your sleep?

a. Nearly every day
b. 3-4 times a week
c. 1-2 times a week
d. 1-2 times a month
e. Never or nearly never

7. During your waking time, do you feel tired, fatigued or not up to par?

a. Nearly every day
b. 3-4 times a week
c. 1-2 times a week
d. 1-2 times a month
e. Never or nearly never

8. Have you ever nodded off or fallen asleep while driving a vehicle?

Yes

No

If yes:

9. **How often does this occur?**

a. Nearly every day
b. 3-4 times a week
c. 1-2 times a week
d. 1-2 times a month
e. Never or nearly never

CATEGORY 3

10. **Do you have high blood pressure?**

a. Yes
b. No
c. I don't know

Scoring Berlin Questionnaire

The questionnaire consists of 3 categories related to the risk of having sleep apnea. Patients can be classified into High Risk or Low Risk based on their responses to the individual items and their overall scores in the symptom categories.

Categories and Scoring:

Category 1: items 1, 2, 3, 4, and 5;
Item 1: if **'Yes',** assign **1 point**
Item 2: if **'c' or 'd'** is the response, assign **1 point**
Item 3: if **'a' or 'b'** is the response, assign **1 point**
Item 4: if 'a' is the response, assign 1 **point**
Item 5: if **'a'** or **'b'** is the response, assign **2 points**
Add points. *Category 1* is *positive if the total score* is *2 or more points.*

Category 2: items 6, 7, 8 (item 9 should be noted separately).
Item 6: if **'a' or 'b'** is the response, assign **1 point**
Item 7: if **'a'** or **'b'** is the response, assign **1 point**
Item 8: if **'a'** is the response, assign 1 **point**
Add points. *Category 2* is *positive if the total score is 2 or more points.*

Category 3 is positive if the answer to item 10 is **'Yes'** or if the BMI of the patient is greater than 30kg/m2.
(BM/ is defined as *weight (kg) divided by height (m) squared, i.e.., kglm2).*

High Risk: if there are 2 or more categories where the score is positive.

Low Risk: if there is only 1 or no categories where the score is positive.

Additional Question: *item* 9 should be noted separately.