NORTHSTAR SLEEP CENTER

NEW PATIENT QUESTIONNAIRE

Please fill out this form entirely before your visit.

Name _____ Sex _____

Address _____

_____ Zip _____

Home Phone _____ Work Phone _____

Occupation _____ Birth Date _____

Age _____ Height _____ Weight _____

Referring Physician _____ Clinic _____

Primary Physician _____ Clinic _____

We will send a copy of your visit to these physicians.

Please avoid wearing perfumes or other strong fragrances when you visit our clinic as it might negatively affect some of our pulmonary patients. Thank you

How would you like to be addressed by our staff during your visit(s)?
i.e.: Bill, Mr. Johnson, Mrs. Green, Ms. Brown, Doctor Smith

_____

Reason for Visit:

Past Medical History: (check each condition that applies to you)

- ☐ Abnormal bleeding
- ☐ Allergies
- ☐ Alpha-1-antitrypsin deficiency
- ☐ Anemia
- ☐ Angina
- ☐ Angioplasty/Stents
- ☐ Anxiety
- ☐ Asbestosis
- ☐ Asthma
- ☐ Blood clots
- ☐ Bronchitis
- ☐ Cancer: _____
- ☐ Chronic Bronchitis
- ☐ Congestive Heart Failure
- ☐ COPD
- ☐ Coronary artery disease
- ☐ Depression
- ☐ Diabetes: _____
- ☐ Drug Resistant Infection (MRSA/VRE)
- ☐ DVT/Blood clot
- ☐ Elevated lipids
- ☐ Emphysema
- ☐ Empyema
- ☐ Fibromyalgia
- ☐ Glaucoma
- ☐ Goodpasture's syndrome
- ☐ Gout
- ☐ Heart disease
- ☐ Hepatitis/liver disease
- ☐ High blood pressure
- ☐ Histoplasmosis
- ☐ HIV/AIDS
- ☐ Insomnia
- ☐ Kidney Disease
- ☐ Lung abscess
- ☐ Lupus
- ☐ Mental Illness
- ☐ Myocardial infarction
- ☐ Obesity
- ☐ Pneumonia
- ☐ Pulmonary Emboli
- ☐ Pulmonary fibrosis
- ☐ Recurrent Sinusitis
- ☐ Restless legs syndrome
- ☐ Rheumatoid arthritis
- ☐ Sarcoidosis
- ☐ Seizures
- ☐ Sleep apnea
- ☐ Sleep walking
- ☐ Stroke/TIA
- ☐ Systemic lupus erythematosus
- ☐ Thyroid disease
- ☐ Toxic exposures
- ☐ Tuberculosis or TB exposure

Please List All Other Major Illnesses:

Please List All Surgeries and Dates:

Family History:

	Alive or Age at Death	Medical History i.e. – lung disease, heart disease, cancer, sleep apnea, etc
Mother		
Father		
Siblings		
Other:		

Social History and Lifestyle:

Do you currently smoke? ☐ Yes ☐ No If a former smoker, what age did you quit? _____

How many packs per day? _____ How many years smoking? _____

Do you feel ready to quit smoking now? ☐ Yes ☐ No ☐ N/A

Do you drink alcohol? ☐ Yes ☐ No ☐ Formerly

Alcohol consumption: _____ number of drinks per ☐ Day ☐ Week ☐ Month ☐ Year

Do you drink caffeine? ☐ Yes ☐ No Type: _____

Caffeine consumption: _____ cups or ounces per day

Current Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Other: _____

Activity level: ☐ Sedentary ☐ Moderate ☐ Vigorous

Type and number of pets in the home: _____

Occupation

Current: _____ If retired, when? _____

Former: _____

Military service? ☐ Yes ☐ No

Toxin exposures? Asbestos: ☐ Yes ☐ No Silica: ☐ Yes ☐ No

Chemicals/Fumes: ☐ Yes ☐ No Type: _____ Other: _____

List hobbies (especially those that expose you to smoke, fumes, dust, chemicals):

_____

Medications: (Please list OR bring a copy of your current list of medications)

Be sure to include all prescription medications, inhalers, nebulizer solutions, over-the-counter medications, vitamins, herbs and supplements.

Medication	Dosage	Times per Day

Allergies: ☐ No Known Drug Allergies

Name of Allergen or Medication	Type of Reaction

Have you ever been allergy tested? ☐ Yes ☐ No Allergy shots? ☐ Yes ☐ No

Relevant X-ray or CT Scans:

******Please plan on bringing any images discs or reports with you.*******

Type of Image	Date	Where Image was Done	Bringing with You?

Review of Systems:

	Yes	No	Comments
GENERAL			
Weight gain			
Weight loss			
Fever/Chills			
Night sweats			
Low energy			
EYES/EARS/NOSE & THROAT			
Difficulty hearing			
Changes in vision			
Nasal congestion			
Nasal drainage			
Post-Nasal Drip			
Sinus pain/pressure			
RESPIRATORY			
Short of breath			
Cough			
Phlegm production			
Cough up blood			
Wheezing			
Snoring			
Stopping breathing at night			
CARDIAC			
Chest pain			
Short of breath while reclining			
Awaken short of breath			
Irregular heartbeat			
Ankle/leg swelling			
GASTROINTESTINAL			
Heartburn/reflux			
Nausea/vomiting			
Vomiting blood			
Difficulty swallowing			
Abdominal pain			
Diarrhea			
Constipation			
Bloody stools			

	Yes	No	Comments
GENITOURINARY			
Bloody urine			
Incontinence			
Nocturia			
IMMUNOLOGIC			
Allergic rhinitis			
Frequent infections			
Food allergies			
METABOLIC/ ENDOCRINE			
Cold intolerance			
Heat intolerance			
Hot flashes			
NEUROLOGICAL			
Migraine headaches			
Numbness/tingling			
Blackouts			
Weakness			
PSYCHIATRIC			
Anxiety			
Depression			
Insomnia			
INTEGUMENTARY			
Hives			
Itching			
Rash			
New lumps			
MUSCULOSKELETAL			
Joint pain/stiffness			
Joint swelling			
Back pain			
Calf pain			
HEMATOLOGICAL			
Anemia			
Enlarged lymph nodes			
Easy bruising			