**Capitol Area Pulmonary Associates**
**3960 Patient Care Dr, Suite 109, Lansing, MI 48911**

# New Patient Questionnaire (ALL patients)

Full Name: _____

Date of Birth: _____

Insurance Provider: _____

Home Address: _____ City_____State_____ Zipcode_____
Phone (Home/Cell): _____
Age: ____ Sex: ____ Marital Status: Married / Single / Other_____
Occupation: _____ Race: _____
Height: _____ Weight: _____
Referring Doctor/Provider: _____

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## Why are you here today?

- Main problems (Circle all that apply):
  - cough / Wheezing / Dyspnea (short of breath) / Abnormal x ray /Ct scan / Hospital FU
  - Snoring / Stopped breathing / Sleepiness / Sleep walking or talking / Trouble falling asleep
- How long has this been a problem? _____ months/years.
- How is this affecting your daily life? _____
- Have you seen a lung/ Sleep doctor before? (Who/When)_____

- **Previous Testing:**
  - Breathing Tests (PFTs): Yes / No. When/Where: _____
  - Chest X-ray or CT Scan: Yes / No. When/Where: _____
  - Past sleep studies Yes / No. When/Where: _____
  - Use CPAP or Oxygen at home? Yes / No. Settings: _____

## PAST Medical/Surgical History

Have you had: Tonsils removed?_____ / Sinus surgery?_____ / Head injury?_____

Weight loss surgery?_____Lung Surgery?_____/ Heart Surgery?_____ Others_____

Circle any conditions you have:
Asthma /COPD/Emphysema. High blood pressure / Heart disease / Diabetes / Acid reflux / Depression or Anxiety / Stroke/ Sleep Apnea/ Insomnia.

Others_____

## Family History

Does anyone in your family have:

Sleep Apnea or Narcolepsy? Yes / No. Who: _____
Cancer: _____Who: _____
COPD / Lung Disease:_____Who: _____
Blood Clots:_____Who: _____

Cardiac disease_____ Who:_____

Others: _____Who:_____

## Lifestyle

Do you smoke? Yes / No. How much? _____ Past smoker? Yes / No. How much a day?_____How many years?_____
Do you drink alcohol? Yes / No. How much? _____
Do you use Marijuana ? Yes / No. How much? _____
Do you use drugs ? Yes / No. How much? _____
Do you have cats at home? Yes / No. Dogs? Yes / No others_____

## REVIEW OF SYSTEMS:

Please circle the following symptoms:

Recent weight change? Yes / No. If yes, gain or loss of: _____ lbs.Time period for weight change: _____ months.
Fatigue / Fever/ Night Sweats / Shortness of Breath / Chronic Cough / Coughing up Blood/ Wheezing / Chest Pain / Heart Palpitations/ Heartburn / Headaches / memory issue/ others:_____, _____ ,_____, _____, _____, _____, _____.

## Current Medications and Allergies:

| Medication | Dose | # Times/Day | Medication | Dose | #Times/Day |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

List other Medications: _____
List Allergies: _____
_____

**Patient name (Printed):_____**

**Signature:_____ Date:_____**

# ***FOR SLEEP PATIENTS ONLY:***

## Sleep Schedule

- Bedtime (Weekdays): _____ (Weekends): _____
- Wake up time (Weekdays): _____ (Weekends): _____
- Do you take naps? Yes / No. How often? _____ times per week. How long? _____
- Do you feel refreshed after a nap? Yes / No
- Do you work night or rotating shifts? Yes / No. Work times: _____

## Please circle your answers:

- Do you snore? Yes / No. Does position matter? Yes / No
- Do you wake up gasping or choking? Yes / No
- Has anyone told you that you stop breathing? Yes / No
- Do you have headaches in the morning? Yes / No
- Do you wake up to use the bathroom more than twice a night? Yes / No
- Do you feel rested in the morning? Yes / No
- Do you wake up with a sour/acid taste in your mouth? Yes / No
- Is it hard to sleep on your back? Yes / No
- Trouble falling asleep? Yes / No. Trouble staying asleep? Yes / No.
- Wake up too early? Yes / No. Racing thoughts at bedtime? Yes / No.
- Falling asleep unexpectedly? Yes / No. While driving? Yes / No.
- Sudden muscle weakness when emotional? Yes / No.
- Cannot move while falling asleep or waking up? Yes / No.
- Dreamlike sounds or images while falling asleep? Yes / No.
- Kicking or jerking legs at night? Yes / No.
- Uncomfortable urge to move legs? Yes / No. Does it happen mostly at night? Yes / No.
- Sleep walking/talking? Yes / No. Act out dreams? Yes / No. Grind teeth? Yes / No

## Sleepiness Scale (0-3)

How likely are you to doze off? 0=Never, 1=Sometimes, 2=Often, 3=Likely

| | |
|---|---|
| Reading while sitting | 0 1 2 3 |
| Watching TV | 0 1 2 3 |
| Sitting in a public place (meeting/theater) | 0 1 2 3 |
| Passenger in a car for 1 hour | 0 1 2 3 |
| Lying down in the afternoon | 0 1 2 3 |
| Talking to someone while sitting | 0 1 2 3 |
| Sitting quietly after lunch | 0 1 2 3 |
| Sitting in a car stopped in traffic | 0 1 2 3 |

**Total Score: _____ / 24**

**Patient name:_____ Signature:_____ Date:_____**