

# 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:** \_\_\_\_\_