HOWARD COUNTY CENTER *for* LUNG AND SLEEP MEDICINE

Patient Health Questionnaire

Please take a few moments to carefully fill out this form with your medical history.

Patient Name: _____ **Date of Birth:** _____

Primary Care Provider: _____ Referring Provider: _____

Reason for this visit/referral: _____

Onset of Problem: _____

Which of the following conditions have you ever been treated for in the past or present?

- ☐ Heart disease
- ☐ Heart murmur
- ☐ Angina
- ☐ High cholesterol
- ☐ Low blood pressure
- ☐ High blood pressure
- ☐ Heartburn/acid reflux
- ☐ Anemia/bleeding problems
- ☐ Myocardial infarction
- ☐ Valvular heart disease
- ☐ Congestive Heart Failure
- ☐ Swollen ankles
- ☐ Vein Problems
- ☐ Diabetes
- ☐ COVID-19
- ☐ COPD
- ☐ Asthma
- ☐ Lung problems
- ☐ Sinus problems
- ☐ Seasonal allergies
- ☐ Cough
- ☐ Tonsillitis
- ☐ Cancer
- ☐ Sexually transmitted disease
- ☐ Arthritis
- ☐ Kidney stones
- ☐ Pacemaker
- ☐ Tuberculosis
- ☐ Seizures
- ☐ Stroke
- ☐ Headache
- ☐ Migraine
- ☐ Neurological problems
- ☐ Depression
- ☐ Anxiety
- ☐ Psychiatric care
- ☐ Liver problems
- ☐ Hepatitis
- ☐ Ulcers
- ☐ Colitis
- ☐ Eye disorder
- ☐ Glaucoma
- ☐ Snoring
- ☐ Sleep Disorder
- ☐ Restless Legs Syndrome
- ☐ Eating disorder
- ☐ Osteoporosis
- ☐ Hernia
- ☐ Thyroid problems
- ☐ Prostate problems
- ☐ Hearing loss
- ☐ Blood clots
- ☐ Ear problems
- ☐ Kidney
- ☐ Bladder problems
- ☐ Sleep Apnea

Please describe any medical condition that is not listed above for which you have been or are being treated:

_____

Past Hospitalizations: Reason & Date

_____

_____

_____

Past Surgical History: Procedure & Date

_____

_____

Medications: List all current medications (Dose & Frequency)

1) _____ 5) _____ 9) _____

2) _____ 6) _____ 10) _____

3) _____ 7) _____ 11) _____

4) _____ 8)_____ 12) _____

List any drug or food allergies:

_____

_____

_____

Family History:	**Living?**	**Age / Age at Death**	**Major illnesses / Cause of death**
Father:	☐ Yes ☐ No	_____	_____
Mother:	☐ Yes ☐ No	_____	_____
Brothers:(#) _____	☐ Yes ☐ No	_____	_____
Sisters: (#) _____	☐ Yes ☐ No	_____	_____

Social History:

Born: (City/State) : _____ Raised: _____ Current Residence: _____

State/country lived in greater than 6 months: _____

Marital Status (circle one): Single/Married/Divorced/Widowed Offspring: # sons _____ # daughters _____

Children: Major Medical Problems: _____

Education(please check highest level): ☐ High school ☐ Trade School ☐ College ☐ Post graduate

Occupational History & Duration:_____

Routine physical exercise? ☐ Yes ☐ No Type: _____ Frequency: _____/week _____/month

Household pets: ☐ In Past ☐ Present Type: ☐ Cats ☐ Dogs ☐ Birds ☐ Other: _____

Tobacco Use: (Cigarettes/Pipe/Cigars/Chew/Vape) ☐ Never

☐ Current: How much? _____ pack/day For how long? _____ years

☐ Quit: When? _____ How much? _____ pack/day For how long? _____ years

Alcohol Use: ☐ Never ☐ Quit (When:_____) ☐ Yes; # drinks: _____ (daily / weekend)

Drug Use: ☐ Never ☐ In Past ☐ Current: _____

Sleep Assessment:

Have you ever been diagnosed with a sleep disorder? YES NO If yes, what sleep disorder? _____

Are you currently using CPAP Therapy? YES NO Do you have any problems with your CPAP?_____

On average, how much sleep do you get each night?_____

How often do have difficulty falling asleep, staying asleep, or waking up too early (without trying to)?_____

Do you follow an irregular sleep schedule that interferes with your waking life?_____

How often do you feel worried, nervous, or on edge… or have less fun than you used to? _____

Epworth Sleepiness Scale

Using the following scale, choose an appropriate number regarding how likely you are to doze off in each of the following situations, in contrast to just feeling tired*:*

0= would never doze off **1**=slight chance of dozing off **2**=moderate chance of dozing off **3**=high chance of dozing off

Situation:	**Rating (circle one):**			
Sitting and reading	0	1	2	3
Watching television	0	1	2	3
Sitting still in a public place (e.g. a theater or meeting)	0	1	2	3
As a passenger in a car for an hour with no break	0	1	2	3
Lying down to rest in the afternoon when circumstances permit	0	1	2	3
Sitting and talking to someone	0	1	2	3
Sitting quietly after a lunch without alcohol	0	1	2	3
In a car, while stopped for a few minutes in traffic	0	1	2	3

Systems Review

Please check all that apply to you in the past <u>3 months</u>:

General
- Weight changes
- Fever or chills
- Unexplained hair loss
- Fatigue
- Weakness
- Trouble sleeping

Head/Eyes/Nose/Throat
- Head/Eyes
- Eye pain
- Head injury
- Vision problems (blurred or loss of vision, etc.)
- Glaucoma
- Cataracts
- Mouth Sores
- Dizziness
- Dental problems
- Deafness
- Ringing in ears
- Hoarseness
- Nose bleed
- Sinus pain
- Hay fever
- Swollen glands
- Sore throat/ pain when swallowing

Cardiovascular
- Fainting spells
- Chest pain
- Heart racing
- Sudden shortness of breath when lying down
- Heart murmur
- Varicose veins
- Blood clots
- Swelling of legs
- Aching/burning in legs
- Leg pain in calf or thigh

Respiratory
- Wheezing
- Shortness of breath
- Night sweats
- Cough
- Coughing up blood
- Painful breathing
- Exposure to tuberculosis

Gastrointestinal
- Pain when swallowing
- Nausea/vomiting
- Blood in stool
- Excessive gas
- Heartburn
- Stomach pain
- Diarrhea
- Constipation

Bladder/Kidneys
- Pain when urinating
- Bladder infection/other infection
- Kidney stones
- More frequent urination
- Blood in urine

Musculoskeletal
- Joint pain/stiffness
- Pain in calf or thigh
- Limited motion of arms or legs
- Swelling or redness

Neurological
- Chronic migraines
- Headaches
- Problems with memory or speech
- Tingling
- Numbness, tingling, or weakness in arms/legs
- Seizures
- Headaches with vision changes

Sleep Symptoms:
- Insomnia
- Daytime sleepiness
- Snoring
- Memory loss
- Restless legs
- Nightmares
- Difficulty falling asleep
- Gasping
- Changes in libido
- Morning headaches
- Coughing at night
- Feeling unrefreshed in the morning

Skin
- Changes in hair/nails
- Changes in skin or texture
- Sores/ulcers
- Rash on palms of hands/feet
- Other skin rash or sores
- New or changing moles

Hematologic
- Anemia
- Blood clots
- Swollen glands (under arms or groin)
- Bruising easily
- Bleeding easily

Psychiatric
- Anxiety
- Depression
- Suicide/homicidal thoughts
- Seeing/hearing things (hallucinations)
- Mood swings

Endocrine
- Excessive sweating
- Increased thirst
- Increased facial hair (females)
- Sensitive to temperature changes
- Changes in appetite
- Increased urination

Vaccinations/Immunizations

Date of last…

TB (PPD): _____

Flu: _____

Pneumonia: _____

Zoster: _____

Covid-19 : _____

Updated 8/4/2021