



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 Visit: _____

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?

- | | | | |
|---|---|--|---|
| <input type="checkbox"/> Heart disease | <input type="checkbox"/> COPD | <input type="checkbox"/> Seizures | <input type="checkbox"/> Snoring |
| <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Asthma | <input type="checkbox"/> Stroke | <input type="checkbox"/> Sleep Disorder |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Lung problems | <input type="checkbox"/> Headache | <input type="checkbox"/> Restless Legs Syndrome |
| <input type="checkbox"/> High cholesterol | <input type="checkbox"/> Cough | <input type="checkbox"/> Migraine | <input type="checkbox"/> Eating disorder |
| <input type="checkbox"/> Low blood pressure | <input type="checkbox"/> Sinus problems | <input type="checkbox"/> Neurological problems | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Seasonal allergies | <input type="checkbox"/> Depression | <input type="checkbox"/> Hernia |
| <input type="checkbox"/> Heartburn/acid reflux | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Anxiety | <input type="checkbox"/> Thyroid problems |
| <input type="checkbox"/> Anemia/bleeding problems | <input type="checkbox"/> Tonsillitis | <input type="checkbox"/> Psychiatric care | <input type="checkbox"/> Prostate problems |
| <input type="checkbox"/> Myocardial infarction | <input type="checkbox"/> Cancer | <input type="checkbox"/> Liver problems | <input type="checkbox"/> Rheumatic fever |
| <input type="checkbox"/> Valvular heart disease | <input type="checkbox"/> Sexually transmitted disease | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Blood clots |
| <input type="checkbox"/> Congestive Heart Failure | <input type="checkbox"/> Hearing loss | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Ear problems |
| <input type="checkbox"/> Swollen ankles | <input type="checkbox"/> Kidney stones | <input type="checkbox"/> Colitis | <input type="checkbox"/> Kidney |
| <input type="checkbox"/> Vein Problems | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Eye disorder | <input type="checkbox"/> Bladder problems |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> 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) _____ | 6) _____ | 11) _____ |
| 2) _____ | 7) _____ | 12) _____ |
| 3) _____ | 8) _____ | 13) _____ |
| 4) _____ | 9) _____ | 14) _____ |
| 5) _____ | 10) _____ | 15) _____ |

List any drug or food allergies:

Family History:**Living?****Age / Age at Death****Major illnesses / Cause of death**

Parents: Father: Yes No _____
 Mother: Yes No _____

Siblings: Male (#) _____ Yes No _____
 Female (#) _____ 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 _____

Offspring 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) 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
 If yes,

How often do you use your CPAP machine? Never 1-3 times per week Every Night

How do you feel in the mornings after using CPAP? Refreshed Fatigued I have nasal congestion / dry mouth

Do you have any problems/complaints about your CPAP? No Mask leaks Yes: _____

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 3 months:

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: _____