www.lungandsleepcenter.com

A. Desai, MD

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Tel: (248) 681-7909 Fax: (248) 681-0455

Name: _____ **DOB:** _____ **Date:** _____

Hospitalizations in the past 12 months? Yes No Where_____

Pulmonary History:

Have you ever been diagnosed with a lung disease? Yes No (circle below)
If so, when _____ **where** _____

Emphysema Chronic Bronchitis COPD Asthma Sarcoidosis
Pneumonia Lung Cancer

When was your last chest xray? _____ last ct scan chest? _____ last breathing test? _____
Do you have Shortness of Breath? Yes No How long? _____
What triggers your shortness of breath? (Circle) Hills, Stairs, Walking, Running, Any Exertion
Do you have a cough? Yes No
Do you bring anything up with the cough? Yes No
What color is it? _____
Do you cough up any blood? Yes No How much? _____How Long? _____
Do you have any wheezing? Yes No
Do you have chest pain? Yes No
Do you have rib pain (pleuritic)? Yes No
Do you have palpitations? Yes No
Do you have any sinus problems? Yes No
Do you have any allergy problems? Yes No
Do you have leg swelling? Yes No
Do you have problems with fatigue? Yes No
Have you ever been exposed to any asbestos or pulmonary hazards in the past? Yes No
Are you using oxygen therapy or nebulizer machine? Yes No DME Company _____

Sleep History:

Have you ever been diagnosed with a sleep disorder? Yes No
If so, when _____ **where** _____
Have you ever been told that you snore? Yes No
Have you ever been told that you stop breathing? Yes No
Do you have daytime sleepiness? Yes No
Do you have Insomnia? Yes No
What time do you go to bed? _____
What time do you wake up? _____
How long does it take you to go to sleep? Minutes Hours
Do you have any interruptions while sleeping? Yes No How many? _____
Do you wake up with an alarm or spontaneously? Do you feel refreshed? Yes No
Do you take any naps? Yes No
How many naps do you take _____per day/week?
Does your naps feel refreshed? Yes No

Do you have any of the following? (Circle)

Drowsy while driving	Dry Mouth	Morning Headaches	Acting out dreams	Night terrors	Sleep Talking
Sleep Paralysis	Hallucinations	Cataplexy	Seizures	Night Sweats	Sleep Eating
Restless leg	Tossing / Turning in bed	Leg Cramps / Twitching	Nightmares	Sleep Walking	Bedwetting

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Personal & Social History:

Occupation: Full Time Part Time Retired Unemployed
Marital Status: M, S, W, D Who do you live with? _____
Smoking: Previous Smoker Current Smoker Never Smoked
(Circle which type) Cigarettes Pipe Cigars
How many years did you smoke for? _____ How may packs per day?_____
How many years has it been since you quit? _____
Alcohol: Yes No Socially Heavy Drinker
Do you drink caffeine? Yes No How many cups per day? _____
Do you do any recreational drugs? Yes No
Do you exercise: Yes No
Do you have any animals? Yes No What kind of animal(s) do you have? _____
Have you had any weight changes? Increased or Decreased and how many pounds? _____
Do you have any hobbies? _____

Family History:

Father: Alive/Deceased, age_____ Any health problems?_____
Mother:Alive/Deceased, age_____ Any health problems?_____
Brothers: How many_____ Any health problems?_____
Sisters: How many _____Any health problems?_____
Any Children: Sons _____Daughters_____ Any health problems?_____

Past Medical History:

Have you ever had any of the following?(Circle)

Stroke	Brain Tumor	Headaches	Seizures
High Blood Pressure	Heart Problems	Gerd	Hernia
Ulcer	Bowel Obstructions	Intestinal Problems	Kidney Problems
Bladder Problems	Prostate Problems	Psoriasis	Eczema
Skin Cancer	Thyroid	Diabetes	Anemia
Leukemia	AIDS	Hepatitis	Depression
Bipolar	Schizophrenia	Anxiety	Panic Disorder
OCD	Mood Swings		

List your surgeries:

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____