Date: _____/_____/_____

HEALTH HISTORY QUESTIONNAIRE

Name: *(Last, First, M.I.)* ☐ **M** ☐ **F**	**DOB** _____/_____/_____

Height: **Weight:** **Name of Pharmacy:** **Phone:**

Referring Physician: **Primary Care Physician:**

Other Physicians:

Advance directive? ☐ Yes ☐ No

PERSONAL HEALTH HISTORY

Main Reason for Today's Visit:

Flu vaccine? ☐ **No** ☐ **Yes, Date:** _____ **Pneumococcal vaccine?** ☐ **No** ☐ **Yes, Date:** _____

List ALL Current medications:

Name:	**Strength:**	**Qty:**	**Frequency:**

Please list any Medical Issues that have been diagnosed by other doctors:
Allergies to Medications: Name: Reaction:
Surgeries: Year: Reason: Hospital:
Hospitalizations: Year: Reason: Hospital:

FAMILY HEALTH HISTORY			
	Yr of Birth	**Age at Death**	**Significant Health Problems or Cause of Death**
Father			
Mother			
Siblings			
Children			
Grandparents			

HEALTH HABITS and SOCIAL HISTORY

Exercise:
☐ Sedentary (No exercise) ☐ Mild Exercise (i.e., climb stairs, walk 3 blocks, golf)
☐ Occasional Vigorous Exercise (i.e., work or recreation, less than 4x/week for 30 min.)
☐ Regular Vigorous Exercise (i.e., work or recreation 4x/week for 30 minutes)

Caffeine:
☐ None ☐ Coffee ☐ Tea ☐ Cola # of Cups/Cans Per Day? _____

Alcohol:
Do you drink alcohol? ..... ☐ Yes ☐ No
If yes, what kind?_____ How many drinks per week? _____

Tobacco:
Are you a: ☐ Former Smoker ☐ Current Smoker ☐ Never smoked
☐ Cigarettes - Pks/day_____ ☐ Chew - #/day _____ ☐ Pipe - #/day _____
☐ Cigars - #/day _____ ☐ # of Years _____ Year Quit _____

Social History:
Where were you born and raised? _____
Occupation: _____
Occupational hazards or exposures: _____

Please answer the following questions.

Do you or has someone told you that you snore or stop breathing in your sleep? ..... ☐ Yes ☐ No
Have you ever woken up choking or gasping for air? ..... ☐ Yes ☐ No
Any memory loss, irritability, or difficulty concentrating? ..... ☐ Yes ☐ No
Do you find yourself increasingly tired during the day? ..... ☐ Yes ☐ No
Do you have a crawling sensation or restless legs? ..... ☐ Yes ☐ No
Do you or have you been told that you kick your legs frequently at night? ..... ☐ Yes ☐ No

REVIEW OF SYSTEMS

Check if you have, or have had, any symptoms in the following areas to a significant degree and briefly explain.

☐ Depression _____
☐ Stress/Anxiety _____
☐ Head/Neck _____
☐ Ears/Nose/Throat _____
☐ Lungs _____
☐ Chest/Heart _____
☐ Intestinal _____
☐ Bladder _____

Recent Changes In:
☐ Weight _____
☐ Energy Level _____
☐ Ability to Sleep _____

Other Issues Not Mentioned Above:
_____
_____
_____

Epworth Sleepiness Scale: Use the scale to rate each situation. **Circle** your level of sleepiness.

0 = wide awake; 1 = slight chance of sleepiness; 2 = moderate chance of sleepiness; 3 = high chance of sleepiness

Sitting and reading	0	1	2	3	Lying down to rest in afternoon	0	1	2	3
Watching television	0	1	2	3	Sitting quietly after lunch	0	1	2	3
Sitting inactive in public place	0	1	2	3	Sitting and talking to someone	0	1	2	3
Passenger in car for more than 1 hour	0	1	2	3	In a car, stopped in traffic	0	1	2	3

Functional Outcomes of Sleep Questionnaire (FOSQ)
Quality of Life Questionnaire

Have the following activities been affected because you have become too sleepy or tired?

0 = Activity does not apply 1 = Yes, extreme 2 = Yes, moderate 3 = Yes, a little 4 = No

Please circle the appropriate number according to the answer key.

1.	Difficulty concentrating on things you do	0	1	2	3	4
2.	Difficulty remembering things	0	1	2	3	4
3.	Difficulty finishing a meal	0	1	2	3	4
4.	Difficulty working on a hobby	0	1	2	3	4
5.	Difficulty doing work around the house	0	1	2	3	4
6.	Difficulty operating a vehicle for short distances	0	1	2	3	4
7.	Difficulty operating a vehicle for long distances	0	1	2	3	4
8.	Difficulty getting things done because you are tired to drive	0	1	2	3	4
9.	Difficulty taking care of financial affairs and doing paperwork	0	1	2	3	4
10.	Difficulty performing employed or volunteer work	0	1	2	3	4
11.	Difficulty maintaining a telephone conversation	0	1	2	3	4
12.	Difficulty visiting with your family or friends in <u>your</u> home	0	1	2	3	4
13.	Difficulty visiting with your family or friends in <u>their</u> home	0	1	2	3	4
14.	Difficulty doing things for your family or friends	0	1	2	3	4
15.	Difficulty maintaining relationships with family/friends	0	1	2	3	4
16.	Difficulty exercising or participating in a sport	0	1	2	3	4
17.	Difficulty watching a movie	0	1	2	3	4
18.	Difficulty enjoying the theater or a lecture	0	1	2	3	4
19.	Difficulty enjoying a concert	0	1	2	3	4
20.	Difficulty watching television	0	1	2	3	4
21.	Difficulty participating in meetings or a group/club	0	1	2	3	4
22.	Difficulty being as active as you want to be in the <u>evening</u>	0	1	2	3	4
23.	Difficulty being as active as you want to be in the <u>morning</u>	0	1	2	3	4
24.	Difficulty being as active as you want to be in the <u>afternoon</u>	0	1	2	3	4
25.	Difficulty keeping pace with others your own age	0	1	2	3	4
26.	Have intimate or sexual relationship been affected?	0	1	2	3	4
27.	Has your desire for intimacy or sex been affected?	0	1	2	3	4
28.	Has your ability to become sexually aroused been affected?	0	1	2	3	4
29.	Has your ability to have an orgasm been affected?	0	1	2	3	4
30.	Rate your general level of activity	1 = Very low		2 = Low	3 = Medium	4 = High