Amarillo Diagnostic Clinic, P.A.

TIM MOORING, M.D.

PATIENT QUESTIONNAIRE - PLEASE PRINT

Full name:_____

Date:_____Age:_____

CHIEF COMPLAINTS(List the problems about which you came to see the doctor)

1) _____

2)_____

3)_____

Referring Physician_____Other Physician_____

PAST MEDICAL HISTORY

Medical illness: Please check any of the following medical illnesses that you now have or have ever had, or list any others that are not listed below.

- ☐ Cataracts
- ☐ Glaucoma
- ☐ Chronic Bronchitis
- ☐ Emphysema
- ☐ Pneumonia
- ☐ Any type of heart problems
- ☐ Heart attack
- ☐ Heart catheterization
- ☐ Rheumatic Fever
- ☐ High blood pressure
- ☐ Stroke
- ☐ High cholesterol
- ☐ Any type of cancer
- ☐ Skin cancer
- ☐ Psoriasis
- ☐ Diabetes
- ☐ Malaria
- ☐ Sexually transmitted disease
- ☐ Tuberculosis
- ☐ Thyroid disease
- ☐ Treatment for depression
- ☐ Tension/Anxiety/Nerves
- ☐ Osteo Arthritis
- ☐ Rheumatoid Arthritis
- ☐ Gallbladder disease
- ☐ Colon polyps
- ☐ Pancreatitis
- ☐ Diverticulosis
- ☐ Liver disease
- ☐ Hepatitis
- ☐ Stomach ulcers
- ☐ Hiatal hernia
- ☐ Kidney problems
- ☐ Kidney stones
- ☐ Miscarriage
- ☐ Blood Clots
- ☐ Stress fractures
- ☐ Other

OPERATIONS OR SURGERIES

Please list all past operations, including cataract surgery, what type of surgery it was and when it was done

Type	Date
Have you ever had a colonoscopy? _____YES _____NO	

Describe any serious accidents or disabling injuries:

Type	Date

Past Hospitalizations		
List your past hospitalizations, year hospitalized and reason for hospitalization		
Hospitalization	**Year Hospitalized**	**Reason**

PLEASE LIST ALL MEDICATIONS THAT YOU ARE CURRENTLY TAKING. BE SURE TO INCLUDE ANY HORMONES, VITAMIN E, NIACIN, FISH OIL, CO-Q 10 & ASPIRIN		
Name	**Dose (ie # of tablets)**	**How often**

Do you take any of the following:

Aspirin	□ Yes	□ No	Birth control pills	□ Yes	□ No	Laxatives	□ Yes	□ No
Hormones	□ Yes	□ No	Vitamins	□ Yes	□ No	Blood thinners	□ Yes	□ No

ALLERGIES

Please list any medications or products you have taken which cause a <u>true</u> allergic reaction (hives, itching, rash, or difficulty breathing):_____

_____

IMMUNIZATIONS

Last flu shot_____ Pneumonia shot □ Yes □ No When?_____

SOCIAL HISTORY

Current employment status: □ Disabled □ Part time □ Full time □ Retired □ Self-employed □ Other

What type of occupation do you (or did) you have?

Where do you live?

Current marital status? □ Single □ Married □ Separated □ Divorced □ Widowed □ Other

How many children do you have? #_____ #_____Sons #_____Daughters

HABITS

Have you ever smoked cigarettes regularly? □ Yes □ No If yes, how many packs per day? (avg)

How many years? Are you still smoking? □ Yes □ No If no, when did you stop?

Do you use snuff or chewing tobacco? □ Yes □ No Do you drink alcohol? □ Yes □ No

How many beers daily? How many years?

How many mixed drinks or glasses of wine daily? How many years?

Do you have any drug, nicotine or alcohol habits which concern you? □ Yes □ No

Do you regularly use sleeping pills, tranquilizers, or pain killers? □ Yes □ No

If yes, which ones?

Do you currently use marijuana, cocaine or other "recreational" drugs? □ Yes □ No

FAMILY HISTORY

Please list any diseases which tend to "run in your family" especially high blood pressure, diabetes, heart disease, cancer, gout, asthma, stomach ulcers, arthritis, allergies, epilepsy, tuberculosis, cystic fibrosis, muscle disease, stroke or thyroid disease.

Father's History

Is your Father? □ Alive – Age _____ □ Deceased – Age _____

What types of health problems if any did he have?

Mother's History

Is your Mother? □ Alive – Age _____ □ Deceased – Age _____

What types of health problems if any did she have?

Do you have any brothers?

How many? □ Alive – Ages _____ □ Deceased – Ages _____

What types of health problems do/did they have?

Do you have any sisters?

How many? □ Alive – Ages _____ □ Deceased – Ages _____

What types of health problems do/did they have?

If you served in the military:

Were you ill while in the military? □ Yes □ No What was the nature of the illness?

Did you serve overseas? □ Yes □ No If yes, where & when?

Have you traveled outside of the Amarillo area in the past year? □ Yes □ No

If so, please list the places you have been:

Please list all pets or any other animals which you may have been in contact with in the past year:

REVIEW OF SYSTEMS

Please check any of the following symptoms or problems you are currently experiencing. If the problem has been resolved, leave it blank. If you are unsure, place a question mark (?) by the medical issue.

General	**Skin**	**Head/Ear/Eyes/Nose/Throat**
□ Weight loss	□ Recent change in hair distribution	□ Diplopia (double vision)
□ Weight gain	□ Changes in skin color	□ Glaucoma
□ Fatigue	□ Itching	□ Hearing loss
□ Fever	□ Rash	□ Nose bleeds
□ Night sweats	□ Hair loss	□ Sore throat
Do you eat a special diet? □Yes □No	□ Other_____	□ Other_____
Do you exercise regularly? □Yes □No		
Neck	**Respiratory**	**Breast/GYN**
□ Neck mass	□ Cough	□ Breast discharge
□ Neck pain	□ History of Tuberculosis	□ Breast swelling □ Breast mass
□ Neck stiffness	□ Shortness of breath	□ Breast tenderness
□ Swollen glands	□ Wheezing	□ Menses:Last one?_____
□ Other_____	□ Other_____	□ # Miscarriage _____
		□ Other_____
Cardiovascular	**Gastrointestinal**	**Genitourinary**
□ Chest pain	□ Abdominal pain	□ Blood in urine
□ Edema (swelling)_____	□ Nausea	□ Dysuria (pain with urination)
□ Fast/Irregular heartbeat	□ Vomiting	□ Frequency of urination
□ Orthopnea (trouble breathing while lying down)	□ Constipation/Diarrhea	□ Discharge
	□ Reflux	□ Nocturia (excessive urination at night)
□ Other_____	□ Other_____	□ History of malignancy (cancer)
		□ Other_____
Musculoskeletal	**Neurological**	**Psychological**
□ Arthritis	□ Headaches	□ Anxiety
□ Back pain	□ Seizures	□ Depression
□ Joint pain	□ Strokes	□ Insomnia
□ Other_____	□ Other_____	□ Other_____
Endocrine	**Hematological**	**Other**
□ Cold intolerance	□ Anemia	
□ Heat intolerance	□ Easy bleeding	
□ Thyroid problems	□ Easy bruising	
□ Other_____	□ Other_____	

Patient Signature _____ **Physician Signature** _____

Date _____ **Date** _____

Revised 08/11/08

We appreciate your cooperation in completing this form for your physician.

Sleep Disorders Center

6700 W. Ninth Ave.
Amarillo, TX 7906
Phone (806) 356-5522
www.adcsleepdisorders.com

THE EPWORTH SLEEPINESS SCALE

Full name:_____ ☐ Male ☐ Female

Date:_____ Age:_____

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling tired? This refers to your usual way of life in recent times. Even if you have not done some of these things recently, try to work out how they would have affected you. Use the following scale to choose the most appropriate number for each situation:

0 = would ***NEVER*** doze

1 = **SLIGHT** chance of dozing

2 = **MODERATE** chance of dozing

3 = **HIGH** chance of dozing

SITUATION	**CHANCE OF DOZING**			
Sitting and reading	0_____	1_____	2_____	3_____
Watching TV	0_____	1_____	2_____	3_____
Sitting, inactive in a public place (e.g. movie theatre or a meeting)	0_____	1_____	2_____	3_____
As a passenger in a car for an hour without a 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 lunch without alcohol	0_____	1_____	2_____	3_____
In a car, while stopped for a few minutes in the traffic	0_____	1_____	2_____	3_____

SLEEP QUESTIONNAIRE

Use the following scale to choose the most appropriate number for each situation:

0 = ***NONE***, not at all, never

1 = ***SLIGHT***, just a few times

2 = ***MODERATE***, sometimes

3 = ***HIGH***, a lot, usually, always or almost always

	SITUATION				
1	Do you feel that you get too little sleep at night?	0_____	1_____	2_____	3_____
2	Do you feel that you get too much sleep at night?	0_____	1_____	2_____	3_____

SLEEP QUESTIONNAIRE CONTINUED

0 = ***NONE*****,** not at all, never
1 = ***SLIGHT*****,** just a few times
2 = ***MODERATE*****,** sometimes
3 = ***HIGH*****,** a lot, usually, always or almost always

	SITUATION				
3	Have you ever had a poor night's sleep?	0_____	1_____	2_____	3_____
4	How great a problem do you have with getting to sleep at night?	0_____	1_____	2_____	3_____
5	How great a problem do you have because of waking up at night?	0_____	1_____	2_____	3_____
6	How great a problem do you have with non-restorative sleep (no matter how much sleep you get, you do not wake up rested)?	0_____	1_____	2_____	3_____
7	How great a problem do you have with tiredness (not sleepiness) during the day?	0_____	1_____	2_____	3_____
8	How great a problem do you have with sleepiness during the day?	0_____	1_____	2_____	3_____

9	On a weekday, what time do you usually go to bed?	_____AM	_____PM
10	On a weekday, what time do you usually get up?	_____AM	_____PM
11	On a weekday, what time do you usually take a nap?	_____AM	_____PM
12	On a weekend or day off, what time do you go to bed?	_____AM	_____PM
13	On a weekend or day off, what time do you get up?	_____AM	_____PM
14	On a weekend or day off, what time do you take a nap?	_____AM	_____PM
15	Do you watch TV or read in bed before going to sleep?	_____YES	_____NO
16	Do you use sleeping aids or medication?	_____YES	_____NO
17	How long after going to bed does it take you to decide to go to sleep?	_____HRS	_____MIN
18	How long does it take you to fall asleep, after you decide to?	_____HRS	_____MIN
19	What is the total number of hours of sleep that you usually get? (Do not include time awake in bed)	_____HRS	_____MIN
20	How many times do you wake up during a typical night?	_____TIMES	
21	How long is a typical wake time?	_____HRS	_____MIN

22	If you do awaken during your normal sleep time, which part(s) of your sleep time is it likely to happened?	First – 1/3	Middle – 1/3	Last – 1/3
23	How many times do you get out of bed during a typical night?	_____Times		
24	How long is the typical longest time out of bed?	_____HRS	_____MIN	

25	When falling asleep, how often do you have thoughts racing through your mind?	0_____	1_____	2_____	3_____

SLEEP QUESTIONNAIRE CONTINUED

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	SITUATION				
26	When falling asleep, how often do you feel sad or depressed?	0_____	1_____	2_____	3_____
27	When falling asleep, how often do you have anxiety (worry about things)?	0_____	1_____	2_____	3_____
28	When falling asleep, how often do you feel muscular tension?	0_____	1_____	2_____	3_____
29	When falling asleep, how often do you feel afraid of not being able to go to sleep?	0_____	1_____	2_____	3_____
30	When falling asleep, how often do you feel unable to move, or feel paralyzed?	0_____	1_____	2_____	3_____
31	When falling asleep, how often do you notice parts of your body startle or jerk?	0_____	1_____	2_____	3_____
32	When falling asleep, how often do you experience restless legs (crawling or aching feelings, unable to keep legs still)?	0_____	1_____	2_____	3_____
33	When falling asleep, how often do you experience vivid, dream-like scenes (hallucinations) even though you are still awake?	0_____	1_____	2_____	3_____
34	When falling asleep, how often do you experience any pain or discomfort?	0_____	1_____	2_____	3_____
35	During the night, how often do you sleep with someone else in your room?	0_____	1_____	2_____	3_____
36	During the night, how often do you sleep with someone else in your bed?	0_____	1_____	2_____	3_____
37	During the night, how often do you sleep on a special bed/mattress?	0_____	1_____	2_____	3_____
38	During the night, how often do you have disturbed, restless sleep?	0_____	1_____	2_____	3_____
39	During the night, how often do you disturb the sleep of your bed partner?	0_____	1_____	2_____	3_____
40	During the night, how often do you provide assistance to someone or something else (child, invalid, pet, etc)?	0_____	1_____	2_____	3_____
41	During the night, how often do you have nasal congestion?	0_____	1_____	2_____	3_____
42	During the night, how often do you snore?	0_____	1_____	2_____	3_____
43	During the night, how often do you hold your breath, or stop breathing?	0_____	1_____	2_____	3_____
44	During the night, how often do you suddenly wake up gasping for air or unable to breath?	0_____	1_____	2_____	3_____
45	During the night, how often do you wake up with a choking sensation?	0_____	1_____	2_____	3_____
46	During the night, how often do you have some other breathing problem?	0_____	1_____	2_____	3_____
47	During the night, how often do you sweat excessively?	0_____	1_____	2_____	3_____

SLEEP QUESTIONNAIRE CONTINUED					
0 = ***NONE*****,** not at all, never		2 = ***MODERATE*****,** sometimes			
1 = ***SLIGHT*****,** just a few times		3 = ***HIGH*****,** a lot, usually, always or almost always			
	SITUATION				
48	During the night, how often do you sleepwalk?	0_____	1_____	2_____	3_____
49	During the night, how often do you sleep talk?	0_____	1_____	2_____	3_____
50	During the night, how often do you grind your teeth?	0_____	1_____	2_____	3_____
51	During the night, how often do you have leg twitching or jerking while you are asleep?	0_____	1_____	2_____	3_____
52	During the night, how often do you have other unusual movement during sleep?	0_____	1_____	2_____	3_____
53	During the night, how often do you get up to eat after going to sleep?	0_____	1_____	2_____	3_____
54	During the night, how often is your sleep disturbed because of stomach or abdominal pains?	0_____	1_____	2_____	3_____
55	During the night, how often is your sleep disturbed because of leg cramps?	0_____	1_____	2_____	3_____
56	During the night, how often is your sleep disturbed because of paresthesia (pins and needles) in your arms and/or legs?	0_____	1_____	2_____	3_____
57	During the night, how often is your sleep disturbed because of an itching sensation?	0_____	1_____	2_____	3_____
58	During the night, how often is your sleep disturbed because of any other kind of pain or intense discomfort?	0_____	1_____	2_____	3_____
59	During the night, how often is your sleep disturbed because of being short of breath in a flat position?	0_____	1_____	2_____	3_____
60	During the night, how often is your sleep disturbed because of “gas” in your stomach, or indigestion?	0_____	1_____	2_____	3_____
61	During the night, how often is your sleep disturbed because of hunger?	0_____	1_____	2_____	3_____
62	During the night, how often is your sleep disturbed because of thirst?	0_____	1_____	2_____	3_____
63	During the night, how often is your sleep disturbed because of awakening with the urgent need to urinate? # times_____	0_____	1_____	2_____	3_____
64	During the night, how often is your sleep disturbed because of intense heart pain (angina)?	0_____	1_____	2_____	3_____
65	During the night, how often is your sleep disturbed because of any other chest pains?				

SLEEP QUESTIONNAIRE CONTINUED

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	SITUATION				
66	During the night, how often is your sleep disturbed because of asthma?				
67	During the night, how often is your sleep disturbed because of persistent coughing?				
68	During the day, how long does it take you to “get going” in the morning?			_____HRS	_____MIN
69	During the day, how often do you feel extremely alert and energetic all day?				