

HeMacinto **Sound Sleep Center**

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Patient General Health Questionnaire

Patient Name: _____ Date of Birth: _____ Sex: M / F
 Height: _____ Weight: _____ Weight last year: _____ Waist: _____ Neck Size: _____
 Emergency Contact: _____ Phone: _____ Relation: _____

Check any of the following symptoms you have had in the past 12 months:

- | <i>Yes</i> | <i>No</i> | | <i>Yes</i> | <i>No</i> | |
|--------------------------|--------------------------|--|--------------------------|--------------------------|-----------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Frequent headaches | <input type="checkbox"/> | <input type="checkbox"/> | Frequent heartburn |
| <input type="checkbox"/> | <input type="checkbox"/> | Fainting | <input type="checkbox"/> | <input type="checkbox"/> | Indigestion |
| <input type="checkbox"/> | <input type="checkbox"/> | Passing out | <input type="checkbox"/> | <input type="checkbox"/> | Abdominal pain |
| <input type="checkbox"/> | <input type="checkbox"/> | Sudden loss of vision or strength | <input type="checkbox"/> | <input type="checkbox"/> | Frequent constipation |
| <input type="checkbox"/> | <input type="checkbox"/> | Inability to speak | <input type="checkbox"/> | <input type="checkbox"/> | Frequent diarrhea |
| <input type="checkbox"/> | <input type="checkbox"/> | Hearing loss or ringing in ears | <input type="checkbox"/> | <input type="checkbox"/> | Rectal bleeding |
| <input type="checkbox"/> | <input type="checkbox"/> | Black Stools | <input type="checkbox"/> | <input type="checkbox"/> | Urinary Incontinence |
| <input type="checkbox"/> | <input type="checkbox"/> | Hoarseness for more than 2-4 weeks | <input type="checkbox"/> | <input type="checkbox"/> | Difficulty urinating |
| <input type="checkbox"/> | <input type="checkbox"/> | Nosebleeds | <input type="checkbox"/> | <input type="checkbox"/> | Blood in urine |
| <input type="checkbox"/> | <input type="checkbox"/> | Cough for more than 2-4 weeks | <input type="checkbox"/> | <input type="checkbox"/> | Urinating more than twice a night |
| <input type="checkbox"/> | <input type="checkbox"/> | Coughing up blood | <input type="checkbox"/> | <input type="checkbox"/> | Pain in joints or bones |
| <input type="checkbox"/> | <input type="checkbox"/> | Shortness of breath or wheezing | <input type="checkbox"/> | <input type="checkbox"/> | Unusual bruising or bleeding |
| <input type="checkbox"/> | <input type="checkbox"/> | Wheezing | <input type="checkbox"/> | <input type="checkbox"/> | Swelling in feet or ankles |
| <input type="checkbox"/> | <input type="checkbox"/> | Epilepsy | <input type="checkbox"/> | <input type="checkbox"/> | Seizures |
| <input type="checkbox"/> | <input type="checkbox"/> | Chest pain, tightness or pressure | <input type="checkbox"/> | <input type="checkbox"/> | Change in wart, mole or skin |
| <input type="checkbox"/> | <input type="checkbox"/> | Irregular or sudden, fast heartbeat | <input type="checkbox"/> | <input type="checkbox"/> | Weight loss of more than 5 lbs. |
| <input type="checkbox"/> | <input type="checkbox"/> | Difficulty swallowing or food “sticking” | <input type="checkbox"/> | <input type="checkbox"/> | Other: _____ |

Past Medical History

- | | | |
|---|---|---|
| <input type="checkbox"/> Hypertension (High Blood Pressure) | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Jaundice |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Hearing Impairment | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Anxiety | <input type="checkbox"/> Fibromyalgia |
| <input type="checkbox"/> Chemical dependency or abuse | <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Reflux |
| <input type="checkbox"/> Lung problems | <input type="checkbox"/> COPD | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> TIA "Light Stroke" | <input type="checkbox"/> Blackouts |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Cancer | <input type="checkbox"/> Thyroid problems |
| <input type="checkbox"/> Stomach or colon problems | <input type="checkbox"/> Back or joint problems (arthritis) | |
| <input type="checkbox"/> Other: _____ | | |

Female Premenstrual Syndrome Menopause Other: _____

Male Prostate problems Erectile dysfunction/impotence Other: _____

Family History

Has an immediate blood relative had any of the following?

- | | | | | | | | |
|--------------------------|--------------------------|-----------------|-------|--------------------------|--------------------------|-----------------|-------|
| Yes | No | Relation | | Yes | No | Relation | |
| <input type="checkbox"/> | <input type="checkbox"/> | Cancer | _____ | <input type="checkbox"/> | <input type="checkbox"/> | Stroke | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Diabetes | _____ | <input type="checkbox"/> | <input type="checkbox"/> | Anxiety | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Hypertension | _____ | <input type="checkbox"/> | <input type="checkbox"/> | Sleep Apnea | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart Disease | _____ | <input type="checkbox"/> | <input type="checkbox"/> | Narcolepsy | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Thyroid Disease | _____ | <input type="checkbox"/> | <input type="checkbox"/> | Other | _____ |

Current Medications	Reason	How Long have you been taking

Epworth Sleepiness Scale

Use the following scale to select the most appropriate number for the situation

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

Sitting and reading -----	0	1	2	3
Sitting inactive in a public place-----	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 permitted-----	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 traffic-----	0	1	2	3
Watching TV-----	0	1	2	3

With the help of a bed partner please circle one of the following as it applies to a typical night.

Snoring	<input type="checkbox"/> Nightly	<input type="checkbox"/> Weekly	<input type="checkbox"/> Rarely	<input type="checkbox"/> Never
Observed pauses in breath	<input type="checkbox"/> Nightly	<input type="checkbox"/> Weekly	<input type="checkbox"/> Rarely	<input type="checkbox"/> Never
Restless or interrupted sleep	<input type="checkbox"/> Nightly	<input type="checkbox"/> Weekly	<input type="checkbox"/> Rarely	<input type="checkbox"/> Never
Awaken short of breath gasps, or snorts	<input type="checkbox"/> Nightly	<input type="checkbox"/> Weekly	<input type="checkbox"/> Rarely	<input type="checkbox"/> Never
Awaken coughing	<input type="checkbox"/> Nightly	<input type="checkbox"/> Weekly	<input type="checkbox"/> Rarely	<input type="checkbox"/> Never
Difficulty falling asleep	<input type="checkbox"/> Nightly	<input type="checkbox"/> Weekly	<input type="checkbox"/> Rarely	<input type="checkbox"/> Never
Leg or body jerks	<input type="checkbox"/> Nightly	<input type="checkbox"/> Weekly	<input type="checkbox"/> Rarely	<input type="checkbox"/> Never
Teeth grinding	<input type="checkbox"/> Nightly	<input type="checkbox"/> Weekly	<input type="checkbox"/> Rarely	<input type="checkbox"/> Never
Vivid dreams	<input type="checkbox"/> Nightly	<input type="checkbox"/> Weekly	<input type="checkbox"/> Rarely	<input type="checkbox"/> Never
Headache	<input type="checkbox"/> Nightly	<input type="checkbox"/> Weekly	<input type="checkbox"/> Rarely	<input type="checkbox"/> Never
Acid indigestion	<input type="checkbox"/> Nightly	<input type="checkbox"/> Weekly	<input type="checkbox"/> Rarely	<input type="checkbox"/> Never
Night sweats	<input type="checkbox"/> Nightly	<input type="checkbox"/> Weekly	<input type="checkbox"/> Rarely	<input type="checkbox"/> Never
Heart palpitations	<input type="checkbox"/> Nightly	<input type="checkbox"/> Weekly	<input type="checkbox"/> Rarely	<input type="checkbox"/> Never
Night time urination	<input type="checkbox"/> Nightly	<input type="checkbox"/> Weekly	<input type="checkbox"/> Rarely	<input type="checkbox"/> Never
Refreshed with morning wake up	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
Dry mouth in morning wake up	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
Sore jaw with morning wake up	<input type="checkbox"/> Yes	<input type="checkbox"/> No		

To the best of my knowledge all of the above information is true and correct.

Patient's Signature

Date