GRANGER
SLEEP & LUNG

Patient History Sleep Form

Date: _____

Name: _____ DOB: _____

Gender: ☐ Male ☐ Female Referring Physician: _____

Email: _____ Primary Care Physician: _____

History

Do you have any of the following Symptoms? Please check all that apply:

- ☐ Morning Headaches
- ☐ Memory Impairment
- ☐ Lack of Energy
- ☐ Obesity
- ☐ Gasping yourself awake
- ☐ Depression
- ☐ Difficulty initiating sleep
- ☐ Use tobacco in the evenings
- ☐ Use illicit drugs
- ☐ Use medication to help you stay awake
- ☐ Snoring
- ☐ Difficulty Concentrating
- ☐ Large Neck Size
- ☐ Daytime Naps
- ☐ Kicking your legs at night
- ☐ Moodiness
- ☐ Drink caffeine in the evenings
- ☐ Use alcohol in the evenings
- ☐ Use medication to aid sleep
- ☐ Been told you hold your breath when you sleep
- ☐ Excessive Daytime Sleepiness
- ☐ Loss of muscle strength when angry or happy
- ☐ Falling asleep while driving
- ☐ Throat hoarseness/irritation
- ☐ Itchy/Crawly sensation in your legs at bedtime
- ☐ Been unable to move upon awakening
- ☐ Awaken earlier than you would like to
- ☐ Thoughts that prevent you from falling asleep

Nighttime: Gasping _____ Choking _____ Coughing _____ Other: _____

What is your usual bedtime? _____ Weekend? _____

What is your usual wake time? _____ Weekend? _____

How many hours of sleep do you usually get? _____ Weekend? _____

Are you a shift worker? ☐ Yes ☐ No If yes, how often do you change shift? _____

Current Shift hours: From _____ To _____ Since (date): _____

STOP-BANG Questionnaire

☐ Yes ☐ No Snoring: Do you snore loudly (louder than talking or loud enough to be heard through closed doors?

☐ Yes ☐ No Tiredness/Fatigue: Do you often feel tired, fatigued, or sleepy during the daytime, even after a good night's sleep?

☐ Yes ☐ No Observed Apnea: Has anyone ever observed you stop breathing during the night?

☐ Yes ☐ No Pressure: Do you have or are you being treated for high blood pressure?

☐ Yes ☐ No Age: Are you older than 50 years?

☐ Yes ☐ No Neck Size: Does your neck measure more than 16 inches (40cm) around?

☐ Yes ☐ No Gender: Are you male?

☐ Yes ☐ No Body Mass Index: Do you weigh more for your height than is shown in the table below?

Height	Weight (lb)	Height	Weight (lb)	Height	Weight (lb)	Height	Weight (lb)
4' 10"	167	5' 3"	197	5' 8"	230	6' 1"	265
4' 11"	173	5' 4"	204	5' 9"	237	6' 2"	272
5' 0"	179	5' 5"	210	5' 10"	243	6' 3"	279
5' 1"	185	5' 6"	216	5' 11"	250	6' 4"	287
5' 2"	191	5' 7"	223	6' 0"	258	6' 5"	295

Weights shown in the table above correspond to a BMI of 35 for a given height

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Epworth Sleepiness Scale

Key

0 = Would ***NEVER*** doze
1 = ***SLIGHT*** Chance of Dozing
2 = ***MODERATE*** Chance of Dozing
3 = ***HIGH*** Chance of Dozing

Situation	Do you ever doze off when... (Use key above)			
Sitting and reading	0	1	2	3
Watching TV	0	1	2	3
Sitting, inactive in a public place (ex: theater, meeting)	0	1	2	3
As a passanger 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 with 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

Previous Sleep Testing

Have you had a previous sleep test? ☐ Yes ☐ No If yes, where?_____

Have you seen a Specialist before? ☐ Yes ☐ No If yes, who?_____

Have you been told you have sleep apnea? ☐ Yes ☐ No

Are you currently on:

☐ Oxygen: How Much _____ How Long_____

☐ CPAP: What Pressure _____ How Long_____

☐ BiPAP: What Pressure _____ How Long_____

If applicable, how do you feel since using the above listed therapy?

☐ Worse ☐ About the same ☐ Better ☐ Much better

*If you see a Granger doctor we have access to your medications there is no need to write them down. (Please attach a list if needed).

Medication:	Dose:	Frequency:

Medication Allergies (please list any allergies to any drugs and reactions, i.e, “Penicillin - Causes rash”):

Medication:	Reaction:	Medication:	Reaction:

Past Medical History: Please check all that apply

☐ No medical problems	☐ High cholesterol	☐ High blood pressure	☐ Pacemaker
☐ Diabetes	☐ High thyroid	☐ Low thyroid depression	☐ Paralysis
☐ Anxiety	☐ Osteoarthritis	☐ Rheumatoid arthritis	☐ Seizure
☐ Stroke	☐ Atrial fibrillation	☐ Seasonal allergies	☐ Headaches
☐ Tremor passing out/fainting	☐ Congestive heart	☐ COPD asthma	☐ Loss of sensation
☐ Other			

Past Surgeries: Please list what year(s)

☐ No past surgeries

☐ Tonsillectomy _____ ☐ Mastectomy _____ ☐ Gallbladder removal _____

☐ Hysterectomy _____ ☐ Vasectomy _____ ☐ C-Section _____

☐ Cancer _____ ☐ Other: _____

Social History:

Occupation: _____

Tobacco: ☐ Yes ☐ No Cigarettes: packs per day Currently Smoking: ☐ Yes ☐ No

Age Started: Age Quit: ____ Cigars: _____ Pipe: _____ Chew: _____

Caffeine: ☐ Yes ☐ No Coffee: ____ cups per day Soda: ___ ounces per day Other: ____ ounces per day

Alcohol: ☐ Yes ☐ No Beer: ___ cans/glasses per week Wine: ___ glasses per week

Hard Liquor: ___ ounces per week

Substance Abuse: ☐ Yes ☐ No If yes: ☐ Marijuana ☐ Cocaine ☐ Methamphetamine ☐ Heroin

Please describe: _____

Family History:

Disease	Relative(s)	Disease	Relative(s)	Disease	Relative(s)
☐ Cholesterol		☐ Heart disease		☐ Sleep abnormalities _____	
☐ Strokes		☐ Heart attacks			
☐ Emphysema		☐ Heart rhythm problems		☐ Cancer (type) _____	
☐ Cystic fibrosis		☐ Kidney diseases			
☐ Early emphysema		☐ Hepatitis		☐ Allergies (type) _____	
☐ Tuberculosis		☐ Diabetes			
☐ Sleep apnea		☐ Asthma		☐ Other (describe) _____	
☐ Hypertension		☐ Thyroid disorder			
				☐ Other (describe) _____	

Review of Symptoms

	Do you currently have (please check appropriate boxes)	Have you ever had (please check appropriate boxes)
General	☐ Weight Gain ☐ Weight Loss ☐ Fever ☐ Rash	☐ Weight Gain ☐ Weight Loss ☐ Fever ☐ Rash
Head	☐ Headache ☐ Head Injury	☐ Headache ☐ Head Injury
Eyes	☐ Vision Changes ☐ Glaucoma ☐ Cataracts	☐ Vision Changes ☐ Glaucoma ☐ Cataracts
Hearing	☐ Hearing Loss ☐ Ringing ☐ Dizziness ☐ Earaches ☐ Infection	☐ Hearing Loss ☐ Ringing ☐ Dizziness ☐ Earaches ☐ Infection
Nose/ Sinuses	☐ Frequent Colds ☐ Nasal Stuffiness ☐ Discharge ☐ Hayfever ☐ Nosebleeds ☐ Sinus Trouble	☐ Frequent Colds ☐ Nasal Stuffiness ☐ Discharge ☐ Hayfever ☐ Nosebleeds ☐ Sinus Trouble
Neck	☐ Lumps	☐ Lumps
Mouth	☐ Sore Throat ☐ Bleeding Gums ☐ Hoarseness	☐ Sore Throat ☐ Bleeding Gums ☐ Hoarseness
Breasts	☐ Lumps or Nipple Discharge	☐ Lumps or Nipple Discharge
Lung Problems	☐ Cough ☐ Sputum ☐ Bloody Sputum ☐ Wheezing ☐ Asthma ☐ Bronchitis ☐ Emphysema ☐ Pneumonia ☐ Short of Breath ☐ Last Chest X-ray Date: _____	☐ Cough ☐ Sputum ☐ Bloody Sputum ☐ Wheezing ☐ Asthma ☐ Bronchitis ☐ Emphysema ☐ Pneumonia ☐ Short of Breath
Heart Problems	☐ High Blood Pressure ☐ Chest Pain or Discomfort ☐ Breathlessness with Exertion ☐ Breathlessness while Lying Flat ☐ Swelling of Lower Extremities ☐ Heart Surgery Date: _____ ☐ Heart Surgery Date: _____	☐ High Blood Pressure ☐ Chest Pain or Discomfort ☐ Breathlessness with Exertion ☐ Breathlessness while Lying Flat ☐ Swelling of Lower Extremities
Endocrine	☐ Thyroid Trouble ☐ Diabetes ☐ Excessive Thirst or Hunger	☐ Thyroid Trouble ☐ Diabetes ☐ Excessive Thirst or Hunger

	Do you currently have (please check appropriate boxes)	Have you ever had (please check appropriate boxes)
Stomach/ Intestinal	☐ Difficulty Swallowing ☐ Painful Swallowing ☐ Heartburn ☐ Decreased Appetite ☐ Nausea ☐ Vomiting ☐ Vomiting Blood ☐ Diarrhea ☐ Constipation ☐ Bleeding from the Rectum ☐ Hemorrhoids ☐ Tarry Black Stools ☐ Abdominal Pain ☐ Liver or Gallbladder Trouble ☐ Hepatitis	☐ Difficulty Swallowing ☐ Painful Swallowing ☐ Heartburn ☐ Decreased Appetite ☐ Nausea ☐ Vomiting ☐ Vomiting Blood ☐ Diarrhea ☐ Constipation ☐ Bleeding from the Rectum ☐ Hemorrhoids ☐ Tarry Black Stools ☐ Abdominal Pain ☐ Liver or Gallbladder Trouble ☐ Hepatitis
Kidneys/ Bladder	☐ Increased Urine Frequency ☐ Increased Urination at Night ☐ Burning or Pain with Urination ☐ Bloody Urine ☐ Difficulty in Starting Urine Stream ☐ Urinary Tract Infections ☐ Kidney Stones	☐ Increased Urine Frequency ☐ Increased Urination at Night ☐ Burning or Pain with Urination ☐ Bloody Urine ☐ Difficulty in Starting Urine Stream ☐ Urinary Tract Infections ☐ Kidney Stones
Male	☐ Hernia ☐ Testicular Pain ☐ Venereal (Sexually Transmitted) Disease ☐ Impotence	☐ Hernia ☐ Testicular Pain ☐ Venereal (Sexually Transmitted) Disease ☐ Impotence
Female	☐ Abnormal Vaginal Bleeding ☐ Venereal (Sexually Transmitted) Disease ☐ Last Pelvic Exam / Pap Smear Date: _____ ☐ Last Breast Exam Date: _____ ☐ Last Mammogram Date: _____	☐ Abnormal Vaginal Bleeding ☐ Venereal (Sexually Transmitted) Disease
Muscle/ Skeletal	☐ Muscle or Joint Pains ☐ Arthritis ☐ Gout ☐ Joint Swelling	☐ Muscle or Joint Pains ☐ Arthritis ☐ Gout ☐ Joint Swelling
Skin	☐ Rash, Dryness, Itching ☐ Psoriasis ☐ Exema	☐ Rash, Dryness, Itching ☐ Psoriasis ☐ Exema
Psychiatric	☐ History of Psychiatric Hospitalization ☐ Depression ☐ Anxiety	☐ History of Psychiatric Hospitalization ☐ Depression ☐ Anxiety
Blood/ Lymph System	☐ Anemia ☐ Easy Bruising or Bleeding ☐ Blood Clots in the Legs or Lungs ☐ Transfusions or Transfusion Reactions ☐ Swollen Lymph Nodes ☐ Lymphoma ☐ Leukemia	☐ Anemia ☐ Easy Bruising or Bleeding ☐ Blood Clots in the Legs or Lungs ☐ Transfusions or Transfusion Reactions ☐ Swollen Lymph Nodes ☐ Lymphoma ☐ Leukemia
Neurologic	☐ Fainting ☐ Seizure ☐ Paralysis ☐ Stroke ☐ Numbness ☐ Tingling ☐ Brain Tumor	☐ Fainting ☐ Seizure ☐ Paralysis ☐ Stroke ☐ Numbness ☐ Tingling ☐ Brain Tumor
Immunologic	☐ Other Allergies _____ ☐ Lupus ☐ Vasculitis	☐ Other Allergies _____ ☐ Lupus ☐ Vasculitis