# PULMONARY CARE SPECIALISTS, PA

**4333 N. Josey Ln., Plaza 2, Suite 207, Carrollton 75010**
**972-394-2971 Fax 972-492-1261**

**James P. Loftin, M.D.** **Melissa L. Tompkins, M.D.**


Dear New Patient;

It is **very important** that you complete the following questionnaire for the appointment you have scheduled on _____. By answering all of the questions as completely as possible before your appointment, you will save considerable time in the doctor's office. If you do not complete this paperwork prior to your appointment, **please arrive an hour early to do so**.

When you arrive for your appointment, please present a current insurance card to the receptionist. If your insurance plan requires a referral from your primary care provider, please bring it with you. **If no referral is presented, the receptionist will have to re-schedule your appointment.** If you do not know if your insurance plan requires a referral, call the benefits phone number on your insurance card and ask.

**Please call twenty-four hours in advance if you are unable to keep your appointment**. Since there are a limited number of new patient appointment times per week, many patients wait one or two months for an appointment. When a new patient does not show up for an appointment or reschedules less than 24 hours in advance, there is not enough time to call a patient who has been waiting for an appointment. Therefore, **due to the high increase in the number of patients not showing up for their scheduled appointment**, if you do not show up for your appointment or reschedule less than 24 hours before your appointment, **we will not be able to reschedule your appointment for a later date.** There will also be a fee of $35.00 billed directly to you and not to your insurance company.

If you have any questions, please call the office where you are scheduled. We look forward to your first visit with our caring staff.

Sincerely,

James P. Loftin, MD
Melissa L. Tompkins, MD
Kathy Deans, PA-C
Ebonyck Simmons, NP-C

# PATIENT SLEEP HISTORY QUESTIONNAIRE

Patient Name: _____ Date: _____

Referring Physician & Phone #: _____

Age: _____ Height: _____ Weight: _____

Have you had a recent weight gain or loss? No _____ Yes _____

If YES, Please explain (ex: how much in what length of time): _____

## MEDICAL HISTORY

Do you now have or have you ever had:

| | | | |
|---|---|---|---|
| High Blood pressure | _____ No _____ Yes | Sinus Problems | _____ No _____ Yes |
| Allergies | _____ No _____ Yes | Heart Problems | _____ No _____ Yes |
| COPD | _____ No _____ Yes | Asthma | _____ No _____ Yes |
| Stroke | _____ No _____ Yes | Tonsillectomy | _____ No _____ Yes |
| Nasal Fracture | _____ No _____ Yes | Nasal Surgery | _____ No _____ Yes |
| Diabetes | _____ No _____ Yes | Multiple Sclerosis | _____ No _____ Yes |
| Nocturnal Esophageal Reflux | _____ No _____ Yes | | |
| Swelling of hands or feet | _____ No _____ Yes | | |
| Laser Surgery for snoring | _____ No _____ Yes | | |

Other Medical Problems: _____

_____

_____

| LIST MEDICATIONS: | TIME OF LAST DOSE | REASON FOR MEDICATION |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

| LIST ALL SURGERIES: | YEAR | LIST ALL SURGERIES: | YEAR |
|---|---|---|---|
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |

MEDICAL ALLERGIES: _____

## SLEEP HISTORY

Describe in detail what your sleep problem is and how long this has been a problem: _____
_____

_____

Normal Bedtime: Weeknights _____ Weekends _____
Normal Wake up Time Weeknights _____ Weekends _____
When you awake in the morning do you feel refreshed? Yes _____ No _____
How long does it usually take you to fall asleep once the lights are turned off? _____
Do you awaken during the night? Yes _____ No _____
How long does it take for you to return to sleep upon these awakenings? _____
Do you take naps during the day? Yes _____ No _____
If YES, How often? _____ Average Length: _____
Do you feel refreshed upon awakening from these naps? Yes _____ No _____
Note the positions you normally sleep in: Back _____ Right Side _____ Left Side _____ Stomach _____
Are you now, or have you ever been, under the care of a cardiologist? Yes _____ No _____
Do you suffer from a racing heart or an irregular heartbeat? Yes _____ No _____
Do you suffer from dizziness, light-headedness, or fainting spell? Yes _____ No _____
Do you ever experience chest pains? Yes _____ No _____
Have you ever had a heart attack or mild cardiac infarction? Yes _____ No _____
Have you ever been diagnosed with a disorder of the central nervous system Yes _____ No _____

Please circle one of the following:
0= Not at all 1= Mild/very rarely/soft 2= Moderate/Occasionally 3= High/Frequently/Loud

| | | | | |
|---|---|---|---|---|
| 1. Do you snore? | 0 | 1 | 2 | 3 |
| 2. Do you snore while lying on your back? | 0 | 1 | 2 | 3 |
| 3. Do you snore while lying on your side? | 0 | 1 | 2 | 3 |
| 4. Rate your snoring. | 0 | 1 | 2 | 3 |
| 5. Do you hold your breath or stop breathing in your sleep? | 0 | 1 | 2 | 3 |
| 6. Do you have difficulty breathing while lying on your back? | 0 | 1 | 2 | 3 |
| 7. Do you have difficulty breathing while lying on your side? | 0 | 1 | 2 | 3 |
| 8. Do you awaken suddenly with a choking sensation or out of breath? | 0 | 1 | 2 | 3 |
| 9. Do you have gas, indigestion or heartburn at night? | 0 | 1 | 2 | 3 |
| 10. Do you have night sweats? | 0 | 1 | 2 | 3 |
| 11. Do you awaken with headaches in the morning? | 0 | 1 | 2 | 3 |
| 12. Do you awaken with a dry mouth? | 0 | 1 | 2 | 3 |
| 13. Do you have trouble breathing through your nose? | 0 | 1 | 2 | 3 |
| 14. Do you experience shortness of breath with exertion? | 0 | 1 | 2 | 3 |
| 15. Do you awaken at night to urinate? | 0 | 1 | 2 | 3 |
| 16. When you awaken from sleep, do you ever feel paralyzed or unable to move even though you are awake? | 0 | 1 | 2 | 3 |
| 17. When someone startles you or makes you laugh, do you get weak, fall or do your knees buckle? | 0 | 1 | 2 | 3 |
| 18. While in the process of falling asleep, do you have vivid dreams or hallucinations? | 0 | 1 | 2 | 3 |
| 19. Do you have frequent uncontrollable bouts of sleep, sleep attacks or an irresistible urge to sleep: | 0 | 1 | 2 | 3 |
| 20. Do your legs kick or twitch frequently during the night? | 0 | 1 | 2 | 3 |
| 21. Do you have restless legs? | 0 | 1 | 2 | 3 |
| 22. Do you have problems with memory or concentration? | 0 | 1 | 2 | 3 |
| 23. Problems with impotence or lack of sexual interest? | 0 | | 2 | 3 |

| | | | | |
|---|---|---|---|---|
| 24. Are you irritable? | 0 | 1 | 2 | 3 |
| 25. Do you feel depressed? | 0 | 1 | 2 | 3 |
| 26. Do you feel anxious? | 0 | 1 | 2 | 3 |
| 27. Do you grind your teeth at night? | 0 | 1 | 2 | 3 |
| 28. Do you feel sleepy during the day? | 0 | 1 | 2 | 3 |
| 29. Do you feel fatigued during the day? | 0 | 1 | 2 | 3 |
| 30. Do you have to fight sleep while driving? | 0 | 1 | 2 | 3 |
| 31. Have you ever had a car wreck caused by sleepiness? | 0 | 1 | 2 | 3 |

Please rate the chance of you dozing in the following situations:

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

Sitting and reading _____

Watching T.V. _____

Sitting inactive in a public place, i.e. theater or meeting _____

As a passenger in a car for a rest in the afternoon _____

Lying down for a rest in the afternoon _____

Sitting and talking to someone _____

In a car while stopped for a few minutes in traffic _____

Sitting quietly after lunch without alcohol _____

Add the numbers for a total TOTAL _____

**SLEEP ENVIROMENT**

Do you sleep in a waterbed? Yes _____ No _____

Do you read in bed? Yes _____ No _____

Do you watch T.V. in bed? Yes _____ No _____

Do you share the bed with anyone? Yes _____ No _____

Does your partner have a sleep disorder? Yes _____ No _____

Do you have pets in the bedroom? Yes _____ No _____

What is the temperature in your bedroom? _____

## SOCIAL HISTORY

Marital Status: _____ Single _____ Married _____ Divorced _____ Separated _____ Other

What is your present occupation? _____

What are your work hours? _____

Have you ever smoked? Yes _____ No _____
If YES, for how many years? _____
Average number of packs per day _____
Have you quit smoking Yes _____ No _____
How long ago? _____

Do you drink caffeinated beverages? Yes _____ No _____
If YES, how much per day? _____

Do you drink alcoholic beverages? Yes _____ No _____
If YES, how often? _____

Do you get regular exercise? Yes _____ No _____
If YES, how often? _____

Do you have any unusual eating habits? Yes _____ No _____
If YES, explain _____

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## FAMILY HISTORY

Children: Number _____ Ages _____ Health _____

Mother: Living _____ Yes_____ No Age _____ Health _____

Father: Living _____ Yes_____ No Age _____ Health _____

Brothers: Ages: _____ Health _____

Sisters: Ages: _____ Health _____

Does any member of your family have sleep problems? If so, please describe:

_____

_____

Now that you have answered your questionnaire, do you have any other comments that you would like to add?

_____

_____

_____

_____