advocare Pulmonary and Sleep Physicians of South Jersey

Pre Op Questionnaire

NAME:_____ DATE:_____

DATE OF BIRTH:_____ AGE:_____ SEX:_____

HOME PHONE:_____ WORK PHONE:_____

CELL PHONE:_____

MARITAL STATUS:
SINGLE:____ MARRIED:____ WIDOW(ER):____ DIVORCED:____ SEPARATED:____

REFERRING PHYSICIAN:_____
FAMILY PHYSICIAN:_____

Please consult your bed partner when answering the following questions. Answer the question as if you are describing your typical night or sleep pattern. If you use CPAP or BIPAP, answer the questions based on your use of CPAP or BIPAP.

1. Describe your sleep problem: _____

_____

2. Have you ever had a sleep study performed? Yes No
   If yes, where did you have the study performed and what were the results: _____

_____

_____

3. Sleep habits:

   work in shifts? Yes No

   A. It usually takes me _____minutes to fall asleep.
   B. I usually wake up _____ times a night.
   C. Please explain what wakes you up: _____

_____

_____

_____

4. My occupation is:_____

5. I snore: Y/N_____

6. I stop breathing at night: Yes _____ No_____. If yes , how often? _____

7. I wake up gasping, wheezing, short of breath, or feeling I cannot breathe: Yes/No _____If yes, how often

8. I wake up coughing. Yes_____No____ If yes, how often? _____

9. I wake up with my heart beating irregularly: Yes ___ No ____ If Yes , how often _____

10. I wake up with heartburn or a sour taste in my mouth Yes___ No___ If yes, how often?_____

11. I wake up with a headache Yes___No____ If yes how often?_____

12. I fight sleep or fall asleep uncontrollably while sitting at meetings, watching TV, at the movies, in the car? Yes_____ No_____ If yes, how often?_____

13. I fight sleep at work or school Yes____No___ If yes, how often?_____

14. I fight sleep while driving Yes___No___ If yes how often?_____

15. I have actually fallen asleep while driving a car: Yes No

16. After a typical nights sleep, I feel: (circle)
Refreshed_____Noy refreshed_____

For the following Y/N If yes, how often?

17. I have been told I toss and turn to an Extreme amount _____

18. I flail or kick while sleeping_____

19. I have the feeling of "restless legs _____

20. I feel like I cannot move after lying down, before going to sleep, when waking up or going to sleep _____

21. I take daytime naps:
If yes, how many naps per day: _____

22. Do you or your bed partner believe that you move your body, arms or legs too much during sleep or have unusual behaviors during sleep?_____

23. Have you ever hurt yourself or your bed partner during sleep.?_____

Medical History Information:

Allergy:_____ Reaction:_____
Allergy:_____ Reaction:_____
Allergy:_____ Reaction:_____

CURRENT MEDICATIONS:

MEDICATION	DOSE/FREQUENCY

If more space is needed, use the back of this page and check here:____

LAST PNEUMONIA VACCINATION:_____
LAST INFLUENZA VACCINATION:_____

MEDICAL PROBLEMS

(Check if you have had any of the following problems):

Asthma	☐	High blood pressure	☐
Atrial fibrillation	☐	Kidney disease	☐
Blood clots	☐	Pulmonary hypertension	
Cancer		Sleep disorders	☐

PAST OPERATIONS

_____
_____
_____
_____
_____
_____

Diabetes	☐	Stroke	☐	_____
Emphysema	☐	Thyroid disease	☐	_____
Heart Attack	☐	Valvular heart disease	☐	_____
Heart Failure	☐			_____

Other: _____

_____

_____

Do you use oxygen? Yes____ No____ If yes, how many liters of oxygen _____

If yes, do you use oxygen All the time With exercise During sleep

Do you smoke cigarettes? Yes____ Never____ Quit____
If quit, how long ago?_____
At what age did you start smoking and what age did you stop? Start_____ Stop_____

How many cigarettes per day? .....

Do you use street drugs now? Yes____ No____

Do you drink alcohol? Yes____ No____

How many drinks? _____ per day _____ per week

Do you drink caffeinated beverages? Yes____ No____

How many caffeinated beverages do you drink per day? (Coffee, tea or soda)_____

What is your occupation?_____

Have you been exposed to chemical, toxins, or asbestos in the past? Yes____ No____

What were the exposures?_____

Do you exercise? Yes____ No ____

What kind of exercise and how often?_____

What health problems have occurred in your family?

Mother:_____ Deceased ☐

Father:_____ Deceased ☐

Brother(s):_____ Deceased ☐

Sister(s):_____ Deceased

Are you currently having any of the following health problems?

GENERAL:

Poor appetite..... Yes ____
Recent weight loss..... Yes ____
Fevers, chills or sweats..... Yes ____
Weight gain.....Yes ____

CARDIOVASCULAR:

Chest pain.....Yes ____
Irregular or fast heart beat.....Yes ____
Swelling in the ankles..... Yes ____
Rheumatic fever..... Yes ____
Sleep with more than 1 pillow at night..... Yes ____
Wake up short of breath at night so that you
sit up during the night..... Yes ____
Pain in your legs when walking..... Yes ____
Elevated cholesterol..... Yes ____
Have you had a stress test?..... Yes ____

EYES, EARS, NOSE, THROAT:

Blurred vision.....Yes ____
Double vision..... Yes ____
Hearing problems..... Yes ____
Sore throat..... Yes ____
Sinus disease..... Yes ____

RESPIRATORY:

Asthma..... Yes ____
Cough with phlegm production..... Yes ____
Cough with blood.....Yes ____
Wheezing..... Yes ____
Shortness of breath with exercise..... Yes ____
Shortness of breath at rest..... Yes ____
Dry cough.....Yes ____
Hay fever.....Yes ____
Exposure to TB..... Yes ____

GI:

Difficulty swallowing solids ..... Yes ____
Difficulty swallowing liquids..... Yes ____
Heartburn..... Yes ____
Ulcers..... Yes ____
Diarrhea..... Yes ____
Nausea and vomiting..... Yes ____
Pain in abdomen..... Yes ____

Blood in stools..... Yes ____
Black stools..... Yes ____
Constipation..... Yes ____
Change in bowel habits..... Yes ____
Vomiting blood..... Yes ____

ENDOCRINE:

Thyroid problems..... Yes ____
Increased thirst..... Yes ____
Increased urination..... Yes ____

NEUROLOGIC:

Headaches..... Yes ____
Seizures..... Yes ____
Weakness in arms or legs..... Yes ____
Previous stroke (s)..... Yes ____
Numbness or tingling..... Yes ____
Dizziness..... Yes ____

GENITOURINARY:

Frequent urination..... Yes ____
Burning with urination..... Yes ____
Blood in urine..... Yes ____
Difficulty starting to urinate..... Yes ____
Vaginal discharge..... Yes ____
Last menstrual period was: _____

HEMATOLOGIC:

Anemia..... Yes ____
Easy bruising..... Yes ____
Nose bleeds..... Yes ____
Frequent infections..... Yes ____

MUSCULOSKELETAL:

Joint pain or swelling..... Yes ____
Arthritis..... Yes ____
Muscle weakness..... Yes ____
Muscle pain..... Yes ____
Color changes in the fingers when it is cold..... Yes ____
Curvature of the spine..... Yes ____

SLEEP:

Snoring at night..... Yes ____
Stop breathing during sleep..... Yes ____
Falling asleep during the day at inappropriate times..... Yes ____
Falling asleep when driving a car or other vehicle..... Yes ____
Restless legs..... Yes ____

SKIN:

Skin cancer..... Yes ____
Skin rash or lumps..... Yes ____

BREAST:

Breast lumps..... Yes ____ No ____
Mammograms..... Yes ____ No ____
Nipple discharge..... Yes ____ No ____

PSYCHIATRIC:

Anxiety..... Yes ____ No ____
Depression..... Yes ____ No ____
Problems with excessive use of alcohol or street drugs..... Yes ____ No ____

Please complete the next page (Epworth Sleepiness Scale)

Patient's signature: _____ Date: _____

Physician's signature: _____ Date: _____

EPWORTH SLEEPINESS SCALE

In contrast to just feeling tired, how likely are you to doze off or fall asleep in the following situations? (This refers to your usual 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
1) Sitting and reading	
2) Watching TV	
3) Sitting inactive in a public place (i.e., a theater or a meeting)	
4) As a passenger in a car for an hour without a break	
5) Lying down to rest in the afternoon when circumstances permit	
6) Sitting and talking to someone	
7) Sitting quietly after lunch without alcohol	
8) In a car, while stopping for a few minutes in traffic	

NAME _____ DATE _____