PATIENT SELF-DIRECTED MEDICAL HISTORY

DATE COMPLETED _____

NAME _____

ADDRESS_____
_____

TELEPHONE _____ _____
_____
HOME WORK CELL

E-MAIL _____ CURRENT PHYSICIAN _____

AGE _____ DOB _____ SEX M_____F _____ HEIGHT _____WEIGHT_____

ARE YOU? MARRIED SEPARATED SINGLE DIVORCED WIDOWED

SPOUSE'S NAME_____CONTACT NUMBER_____

ARE YOU CURRENTLY WORKING? (please circle response) YES NO

IF YES, WHAT IS YOUR OCCUPATION?

_____

IF NO, ARE YOU? (please circle response)

DISABLED RETIRED UNEMPLOYED TEMPORARY DISABILITY (date)

WHAT ETHNIC GROUP DO YOU IDENTIFY YOURSELF?

_____ BLACK
_____ CAUCASIAN
_____ ASIAN
_____ LATINO
_____ PACIFIC ISLANDER
_____ AMERICAN INDIAN
_____ OTHER _____
_____ UNKNOWN

WHAT ETHNIC GROUP IS YOUR MOTHER AND FATHER

MOTHER	FATHER
_____ BLACK	_____ BLACK
_____ CAUCASIAN	_____ CAUCASIAN
_____ ASIAN	_____ ASIAN
_____ LATINO	_____ LATINO
_____ PACIFIC ISLANDER	_____ PACIFIC ISLANDER
_____ AMERICAN INDIAN	_____ AMERICAN INDIAN
_____ OTHER _____	_____ OTHER _____
_____ UNKNOWN	_____ UNKNOWN

DO YOU HAVE CHILDREN? (Names and ages)

_____
_____
_____
_____
_____
_____
_____

Please list all of your medications, including over the counter, vitamins and herbal supplements.

MEDICATIONS	DOSE (mg, puffs, squirts Units)	HOW OFTEN?

List of your medical problems and year of diagnosis, and include surgeries.
(*Example: diabetes mellitus, 1980; appendectomy,1945; sleep apnea,1999*)

Have you had a chest x-ray recently? YES NO

When? _____ Where _____

Have you had a CT scan of the chest recently? YES NO

When? _____ Where? _____

Have you had chest surgery? YES NO

Why? _____

When? _____ Where _____

Have you had a bronchoscopy? YES NO

Why? _____

When? _____ Where _____

Have you had a sleep study? YES NO

What was the name and address of the sleep center?

_____

_____

_____

When was the
study?_____

If you have had more than one sleep study list the names and addresses of the other studies

_____

_____

_____

When was the
study?_____

_____

_____

_____

When was the
study?_____

Have you had a pneumonia shot? YES NO
When? _____

Have you had a skin test for tuberculosis? YES NO
When? _____

Results Don't remember Positive Negative

Have you ever smoked cigarettes? YES NO

Do you currently smoke cigarettes? YES NO

How many years have you smoked cigarettes?_____

How many packs of cigarettes per day have you smoked?_____

If you have quit and no longer smoke, when did you quit?_____

If you are a current smoker, have you ever quit before? YES NO
How many times? _____

Have you ever smoked cigars? YES NO

How many and how long?_____

Have you ever consumed alcoholic beverages? YES NO
If yes, how much do or did you drink?_____

Do you still consume alcohol? YES NO

If you used to consume alcoholic beverages, how much did you drink and when did you quit?
Amount_____Quit Date_____

Did you ever use illicit or recreational drugs such as marijuana, speed, downers, LSD, heroin? YES NO

Do you still use these drugs? YES NO
If yes, how much and how often? _____
If no, when did you quit?_____

Have you had any serious injuries? YES NO
(fractures, dislocations, blunt trauma, concussions, neck, and back injuries)
Explain._____
_____
_____

Do you exercise? YES NO
If yes, how long and how often? _____

How many caffeinated beverages do you drink per day?
Tea_____ Caffeinated coffee_____ Soft Drinks _____

What states and countries where you have lived and when you lived in those residences.

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

List all the jobs you have worked and with any workplace exposures.

JOB	When	Hazardous exposures
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

What pets do you have at home?

_____
_____

Is your mother? LIVING DECEASED

Age _____ Health Conditions _____

Is your father? LIVING DECEASED

Age _____ Health Conditions _____

Do you have any brothers or sisters? YES NO
If yes, see below.

List (Name)	Age	Living or deceased	Health Conditions

What are some of your stresses in your life at this time?

Do you sleep well at night? YES NO
Do you have difficulty staying awake during the day? YES NO

How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired? This refers to your usual way of life in recent times. Even if you haven't done some of these things recently, try to work out how they would have affected you now. 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 televison	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 after noon 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 traffic	0 1 2 3

Total _____