PHYSICIANS EAST P.A.
PROVIDING COMPREHENSIVE HEALTH CARE TO EASTERN NORTH CAROLINA

PE#
Date:

PERSONAL HISTORY FORM

LAST NAME: _____
FIRST NAME: _____
DATE AND PLACE OF BIRTH: _____
ADDRESS: _____
PHONE: _____ **EMAIL:** _____
ALTERNATE PHONE: _____

CHIEF COMPLAINT: _____
PRIMARY PROVIDER: _____

PAST MEDICAL HISTORY:

- ☐ Asthma
- ☐ Anemia
- ☐ Bleeding disorder
- ☐ Bronchitis
- ☐ High cholesterol
- ☐ Diabetes
- ☐ Fibromyalgia
- ☐ Coronary artery disease
- ☐ High blood pressure
- ☐ HIV
- ☐ Inflammatory bowel disease
- ☐ Kidney disease
- ☐ Migraines
- ☐ Osteoporosis
- ☐ Osteoarthritis
- ☐ Prostate disease
- ☐ Seizures
- ☐ Stroke
- ☐ Thyroid disease
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Others
- ☐ _____

PAST SURGERIES: _____

ALLERGIES: _____

SOCIAL HISTORY:

- ☐ Marital status _____
- ☐ Alcohol use _____
- ☐ Tobacco use _____
- ☐ Pack years? _____
- ☐ Year stopped _____
- ☐ Illicit drug use _____
- ☐ Occupation _____
- ☐ Caffeinated drinks

Past blood transfusions?

VACCINATIONS:

- ☐ Flu shot
- ☐ Pneumovax
- ☐ Hepatitis
- ☐ Tetanus
- ☐ Other

FAMILY HISTORY: CHILDREN _____ **SIBLINGS:** _____ **PARENTS:** _____

- ☐ Asthma
- ☐ Bleeding disorder
- ☐ High cholesterol
- ☐ Diabetes
- ☐ Coronary artery disease
- ☐ High blood pressure
- ☐ Kidney disease
- ☐ Osteoarthritis
- ☐ Prostate disease
- ☐ Seizures
- ☐ Stroke
- ☐ Thyroid disease
- ☐ Cancer
  - ○ Breast
  - ○ Lung
  - ○ Colon

ADVANCE DIRECTIVES / LIVING WILL: _____ **OTHER:**

PE#
Date:

REVIEW OF SYSTEMS

DO YOU SUFFER FROM, FREQUENTLY EXPERIENCE OR NOTICE: PLEASE MARK AS APPLY

Constitutional:
- ☐ Fever/shaking chills
- ☐ Change in weight
- ☐ Excessive fatigue or weakness

Lung/Pulmonary:
- ☐ Hoarseness or change in voice
- ☐ Chronic cough or sputum production
- ☐ Coughing up blood
- ☐ Shortness of breath
  - o Doing your usual work
  - o Climbing a flight of stairs
  - o Which awakens you at night
  - o Which causes you to cough
  - o Accompanied by wheezing

Sleep:
- ☐ Sleepiness in daytime
- ☐ Snore excessively or loudly
- ☐ Sleep paralysis
- ☐ Restless legs
- ☐ Drop attacks
- ☐ Hallucinations upon awakening
- ☐ Paralysis upon awakening

Cardiovascular:
- ☐ Fluid retention in feet or legs
- ☐ Frequent cramps in legs at walking
- ☐ Varicose veins or phlebitis
- ☐ Palpitations or irregular heartbeat
- ☐ Chest pain, tightness or pressure
  - o When exerting yourself
  - o Radiates to arm or neck
  - o Disappears if you rest
  - o After a heavy meal
  - o When upset or excited
  - o When walking in cold weather

Gastrointestinal:
- ☐ Loss of appetite
- ☐ Trouble swallowing
- ☐ Frequent heartburn
- ☐ Pain after meals or spicy foods
- ☐ Pain relieved by antacids

Renal-Urinary:
- ☐ Loss of control of bladder
- ☐ Blood in urine
- ☐ Getting up frequently at night

Endocrine:
- ☐ Do you have excessive thirst
- ☐ Do you feel anxious
- ☐ Are you sensitive to cold

Rheumatologic:
- ☐ Joints or muscles ache frequently
- ☐ Frequent joint swelling or redness
- ☐ Chronically dry eyes or mouth

Hematologic:
- ☐ Noticed lymph node swelling or enlargement
- ☐ Frequent nosebleeds
- ☐ History of anemia

Psychologic:
- ☐ Trouble sleeping
- ☐ Depressed, lonesome or worried
- ☐ Alcohol-drug dependency problem
- ☐ Unhappy with your life

Neurologic:
- ☐ Numbness, weakness or tingling
- ☐ Frequent headaches
- ☐ Dizziness

Genital:
- ☐ Loss of sexual activity/desire
- ☐ Still having regular periods
- ☐ Do you use birth control
- ☐ Prostrate trouble
- ☐ Hernia trouble

Skin:
- ☐ Noticed any changes in warts or moles
- ☐ Do you bruise easily
- ☐ Noticed new skin spots, rashes or sores
- ☐ Dry, scaly skin

PHYSICIANS EAST P.A.

PROVIDING COMPREHENSIVE HEALTH CARE TO EASTERN NORTH CAROLINA

Date: _____
Chart #: _____
Provider: _____

SLEEP QUESTIONNAIRE

How long have you had a problem with your sleep?

_____

Do you consider your sleep problem to be:
mild moderate severe
Do any family members have a sleep problem?
yes no
Do you work shifts?
split shift rotating shift night shift

Sleep Schedule

Normal bedtime on weekday: _____
Normal wakeup time on weekday: _____
Normal bedtime on weekend: _____
Normal wakeup time on weekends: _____

Do you wake up during the night?
yes no
Do you wake up to go to the bathroom?
yes no
Do you wake up early in the morning?
yes no
Do you have difficulty falling asleep?
yes no
Do you have difficulty staying asleep?
yes no
Do you have difficulty waking up?
yes no
Do you nap during the:
day evening How long? ____
Do you dream when you nap?
yes no
Do you have excessive daytime sleepiness?
yes no
Do you have morning headaches?
yes no
Do you awaken short of breath?
yes no
Do you have nighttime heartburn?
yes no
Do you snore?
yes no
Do others complain of your snoring?
yes no

Have you ever awakened.....

Have you ever awakened choking and gasping for air?
yes no
Have you ever awakened with your heart beating irregularly? yes no
Have you ever awakened from sweating excessively?
yes no
Others observe breathing problems?
yes no

Do you fall asleep.....

Do you fall asleep during the day?
yes no
Do you fall asleep during physical effort?
yes no
Do you fall asleep involuntarily?
yes no
Do you fall asleep while laughing?
yes no
Do you fall asleep while crying?
yes no
Do you feel unable to move when waking up or falling asleep? yes no
Experience vivid dream-like scenes upon awakening or falling asleep? yes no
Have trouble at work/school because of sleepiness?
yes no

Do you.....

Do you have nightmares?
yes no
Do you feel sad or depressed?
yes no
Do you feel afraid to go to sleep?
yes no
Do you remember dreams?
yes no
Do you have anxiety?
yes no
Do you feel you won't be able to sleep?
yes no
Do you kick during the night?
yes no
Do you have body pain at night?
yes no
Do you have jaw pain?
yes no
Do you have leg pain?
yes no
Do you have crawling/aching feeling in your legs?
yes no

When you wake up, do you.....

When you wake up, do you feel stiff?
yes no
When you wake up, do you have a dry mouth?
yes no
When you wake up, do you have sore achy muscles?
yes no
When you wake up, do you feel tired?
yes no

Physicians East P.A. - Sleep Center
1711 East Arlington Blvd.
Greenville, NC 27858
(252) 413-6360 • Fax: (252) 756-0228
Sleep Clinic: (252) 413-6714

Epworth Sleepiness Scale

The Epworth Sleepiness Scale is a measurement of how likely you are to doze off or fall asleep in various situations, compared to feeling just tired. Use the following number scale to choose the best match for each situation.

0 = No chance of dozing

1 = Slight chance of dozing

2 = Moderate chance of dozing

3 = High chance of dozing

Situation

1. Sitting and Reading_____
2. Watching TV_____
3. Sitting inactive in a public place (example: theater or meeting)_____
4. As a passenger in a car for an hour_____
5. Lying down to rest in the afternoon_____
6. Sitting and talking to someone_____
7. Sitting quietly after lunch (without alcohol)_____
8. In a car while stopped in traffic for a few minutes_____

Total Score_____