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NEUROLOGY & SLEEP MEDICINE

www.DallasNeurology.com – www.SleepDisordersClinic.com

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**HISTORY FORM**

1 of 4

Date: \_\_\_\_\_ Referring Physician: \_\_\_\_\_

Name Last: \_\_\_\_\_ First \_\_\_\_\_ DOB: \_\_\_\_\_

SSN: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Neck Girth: \_\_\_\_\_ Gender: M F

Occupation: \_\_\_\_\_ Handedness: R L

**Chief Complaint:** Describe your present complaints: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Neurological:** Do you have any of the following complaints at present? (Check the box and describe above)

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Headache                                | <input type="checkbox"/> Nausea/vomiting        | <input type="checkbox"/> Falls                    |
| <input type="checkbox"/> Loss of consciousness                   | <input type="checkbox"/> Dizziness              | <input type="checkbox"/> Hearing problems         |
| <input type="checkbox"/> Difficulty with vision or double vision | <input type="checkbox"/> Difficulty with speech | <input type="checkbox"/> Memory problems          |
| <input type="checkbox"/> Difficulty passing urine                | <input type="checkbox"/> Difficulty walking     | <input type="checkbox"/> Difficulty in swallowing |
| <input type="checkbox"/> Difficulty using hands                  | <input type="checkbox"/> Sleep problems         | <input type="checkbox"/> Numbness or tingling     |
| <input type="checkbox"/> Pain in any part of body(describe)      | <input type="checkbox"/> Tremor                 | <input type="checkbox"/> Seizures or epilepsy     |
| <input type="checkbox"/> Muscle paralysis                        | <input type="checkbox"/> Other: _____           |   |

**Review of systems:** Do you have any of the following problems at present?(Check box and describe) RJ, MD, PA

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Fever/chills/night sweats | <input type="checkbox"/> Weight loss or gain   | <input type="checkbox"/> Skin rash                    |
| <input type="checkbox"/> Palpitations              | <input type="checkbox"/> Weakness              | <input type="checkbox"/> Ear, nose and throat disease |
| <input type="checkbox"/> Breast disease            | <input type="checkbox"/> Heart disease         | <input type="checkbox"/> Cough                        |
| <input type="checkbox"/> Chest pain                | <input type="checkbox"/> Shortness of breath   | <input type="checkbox"/> Bleeding disorder            |
| <input type="checkbox"/> Thyroid disorder          | <input type="checkbox"/> Constipation/diarrhea | <input type="checkbox"/> Allergic disorder            |
| <input type="checkbox"/> Urinary complaints        | <input type="checkbox"/> Sexual complaint      |   |
| <input type="checkbox"/> Other: _____              |  |   |

**For Women:**

Are you pregnant? \_\_\_\_\_ Yes  No

Are you planning on having children within the next one year? Yes  No

Are you taking birth control pills? \_\_\_\_\_ Yes  No

Are you using any other contraceptive measures? \_\_\_\_\_ Yes  No

Have you had a hysterectomy or tubal ligation? \_\_\_\_\_ Yes  No

Do you have menstrual problems? \_\_\_\_\_ Yes  No

\_\_\_\_\_

Name:

Last: \_\_\_\_\_ First: \_\_\_\_\_

DOB: \_\_\_\_\_ SSN: \_\_\_\_\_

<b>HISTORY FORM</b> 2 of 4
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<b>Past Medical History:</b> Have you ever been diagnosed with the following conditions?				RJ, MD, PA
<input type="checkbox"/> Hypertension	<input type="checkbox"/> Emphysema / COPD	<input type="checkbox"/> Cholesterol	<input type="checkbox"/> Sinus Disease	
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Chronic Fatigue	<input type="checkbox"/> Peptic Ulcer	<input type="checkbox"/> Seizures / Epilepsy	
<input type="checkbox"/> Heart Problems	<input type="checkbox"/> Depression	<input type="checkbox"/> Bleeding Problems	<input type="checkbox"/> Mental Problems	
<input type="checkbox"/> Cancer	<input type="checkbox"/> HIV, Hepatitis, etc	<input type="checkbox"/> Stroke	<input type="checkbox"/> Other (describe)	
_____				

<b>Past Surgical History:</b> (Give name and date of any operations which you have had in the past)		RJ, MD, PA
_____		
_____		
Have you had any accidents or injuries in the past?		
_____		
Have you been hospitalized recently? If yes, give details:		
_____		

<b>Medications:</b> (List all medications)		RJ, MD, PA
_____	_____	
_____	_____	
_____	_____	
_____	_____	
_____	_____	
Do you take Aspirin daily? Yes <input type="checkbox"/> No <input type="checkbox"/> For how long?		

<b>Allergies:</b> (Medication & food)		RJ, MD, PA
_____		
_____		

<b>Family History:</b> (State the health information of the following)		RJ, MD, PA
Children	Maternal Grandparents	
Siblings	Paternal Grandparents	
Parents	Extended Family	
Are you adopted? <input type="checkbox"/> Yes <input type="checkbox"/> No:		
_____		
Does any hereditary condition run in your family?		
_____		

Name:

Last: \_\_\_\_\_ First: \_\_\_\_\_

DOB: \_\_\_\_\_ SSN: \_\_\_\_\_

**HISTORY FORM**  
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Do your parents, siblings or children have any of the following?(please check box if present) RJ, MD, PA

- |  |  |
|--|--|
| <input type="checkbox"/> Similar type of illness that you have now | <input type="checkbox"/> Alzheimer's                     |
| <input type="checkbox"/> Stroke                                    | <input type="checkbox"/> Cancer                          |
| <input type="checkbox"/> Migraines                                 | <input type="checkbox"/> Diabetes                        |
| <input type="checkbox"/> High blood pressure                       | <input type="checkbox"/> Epilepsy                        |
| <input type="checkbox"/> Heart problems                            | <input type="checkbox"/> Depression or nervous breakdown |
| <input type="checkbox"/> Parkinson's or tremor                     | <input type="checkbox"/> Muscle or nerve disease         |
| <input type="checkbox"/> Other: _____                              |  |

**Personal and Social History:** RJ, MD, PA

Tobacco	Do you smoke Have you ever smoked ?	Yes <input type="checkbox"/> No <input type="checkbox"/> , How much? _____ Yes <input type="checkbox"/> No <input type="checkbox"/>
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Alcohol	Do you take alcohol Have you ever taken alcohol ?	Yes <input type="checkbox"/> No <input type="checkbox"/> , How much? _____ Yes <input type="checkbox"/> No <input type="checkbox"/>
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Caffeine	Do you take caffeine? Yes <input type="checkbox"/> No <input type="checkbox"/> , Tea/Coffee <input type="checkbox"/> Soda <input type="checkbox"/> How many per day? _____
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Illicit Drugs	Do you take Illicit drugs Have you ever taken Illicit drugs ?	Yes <input type="checkbox"/> No <input type="checkbox"/> Names: _____ Yes <input type="checkbox"/> No <input type="checkbox"/>
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Regular Exercise \_\_ Yes  No  \_\_\_\_\_ Who do you live with? \_\_\_\_\_

Your level of education \_\_\_\_\_ Your Hobbies \_\_\_\_\_

Your spouse's job \_\_\_\_\_

Comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Sleep Environment: (For patients with sleep problems only)** RJ, MD, PA

What time do you go to sleep on weekdays? \_\_\_\_\_

What time do you go to sleep on weekends? \_\_\_\_\_

Usual wake up time on weekdays? \_\_\_\_\_

Usual wake up time on weekends? \_\_\_\_\_

Average number of awakenings during night? \_\_\_\_\_

Do you read in bed? \_\_\_\_\_ Yes  No

Do you carry work to bed? \_\_\_\_\_ Yes  No

Do you watch TV from bed? \_\_\_\_\_ Yes  No

Does your bed partner have sleep disorder? \_\_\_\_\_ Yes  No

Do you nap during day time? \_\_\_\_\_ Yes  No  , If Yes, How long? \_\_\_\_\_

Name:

Last: \_\_\_\_\_ First: \_\_\_\_\_

DOB: \_\_\_\_\_ SSN: \_\_\_\_\_

**HISTORY FORM**  
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**Sleep History:** (For patients with sleep problems only)

RJ, MD, PA

Please answer the following from a scale of 0 to 3.

0 - not at all      1 - mild                      2 - moderate                      3 - severe

- Do you have trouble falling asleep? \_\_\_\_\_ 0 1 2 3
- Do you have trouble remaining asleep? \_\_\_\_\_ 0 1 2 3
- Do you snore? \_\_\_\_\_ 0 1 2 3
- Does your breathing stop at night? \_\_\_\_\_ 0 1 2 3
- Do you have to pass urine at night? \_\_\_\_\_ 0 1 2 3
- Do you suffer from heartburns at night? \_\_\_\_\_ 0 1 2 3
- Do you kick your legs at night? \_\_\_\_\_ 0 1 2 3
  
- Do you have sweating at night? \_\_\_\_\_ 0 1 2 3
- Do you grind your teeth at night? \_\_\_\_\_ 0 1 2 3
- Do you experience an inability to move while falling asleep? \_\_\_\_\_ 0 1 2 3
- Do you see any unusual vision at sleep onset? \_\_\_\_\_ 0 1 2 3
  
- Do you feel groggy on awakening? \_\_\_\_\_ 0 1 2 3
- Do you suffer morning headaches? \_\_\_\_\_ 0 1 2 3
- Do you wake up with a dry mouth? \_\_\_\_\_ 0 1 2 3
- Do you have nightmares? \_\_\_\_\_ 0 1 2 3
- Have you suffered from a seizure in your sleep? \_\_\_\_\_ 0 1 2 3
  
- Are you sleepy during the daytime? \_\_\_\_\_ 0 1 2 3
- Do you feel fatigued during the daytime? \_\_\_\_\_ 0 1 2 3
- Do you have to fight sleep while driving? \_\_\_\_\_ 0 1 2 3
- Do you suffer from attacks of loss of strength when startled? \_\_\_\_\_ 0 1 2 3
- Do you suffer from memory problems? \_\_\_\_\_ 0 1 2 3
- Have you ever had a motor vehicle accident due to sleepiness?    Yes  No  Describe \_\_\_\_\_

**Epworth Sleepiness Scale:**

How likely are you to doze off or fall asleep in the following situations?

0 = Never, 1 = Slight, 2 = Moderate, 3 = High chance

SITUATION	CHANCE OF DOZING
Sitting and Reading _____	0 1 2 3
Watching television _____	0 1 2 3
Sitting inactive in a public place (such as a theater) _____	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 afternoon _____	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 stopping for a few minutes in traffic _____	0 1 2 3

*I have reviewed and completed all 4 pages of this form,*

Patient Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_