



Kwaku Osafo-Mensah, MD

Pulmonary Critical Care and Sleep Medicine
Advanced, personalized care for exceptional outcomes.

NAME _____ DOB: _____ DATE/TIME: _____

Has your insurance information changed? Yes _____ No _____

ALLERGIES TO MEDICATIONS: _____

PLEASE CIRCLE RECENT SYMPTOMS:

CONSTITUTIONAL: Fever, chills, night sweats, fatigue, changes in voice, weight loss/gain

EYE: Changes in vision, pain, itchiness, yellowish of eye, discharge

ENT: Sore throat, nosebleeds, nasal stuffiness or discharge, sinus problems

RESPIRATORY: Cough, shortness of breath, decrease exercise level, cough up blood, exposure or history of TB, exposure to toxin/chemicals, exposure to secondhand smoke, snore, home oxygen use, CPAP use, nebulizer use

CARDIAC: Chest pain, shortness of breath with activity, short of breath lying down, palpitation, Swelling on hands, feet, or whole body

GU: Painful urination, frequent urination, blood in urine, need of dialysis, loss of bladder control

INTEGUMENTARY: Rash, blisters, discoloration of skin, sun sensitivity

HEM/LYMPH: Bruising, bleeding problems, recent transfusion, enlarged lymph nodes, spleen removed

ALLERGY: Seasonal allergies, grass, pollen, dust mites, trees, feathers

ENDOCRINE: Heat intolerance, cold intolerance, frequent urination, frequent thirst, tiredness

GI: Nausea, vomiting, heartburn or reflux, diarrhea, constipation, black stools, abdominal pain

MUSCULOSKETAL: Arthritis, joint pain, joint swelling, back pain acute or chronic, muscle cramps or pain, calf or ankle pain

NEUROLOGY: Headaches, nervousness, daytime sleepiness, weakness, falls, shakes

PSYCHIATRY: Depression, anxious, suicidal, forgetful, stress, crying a lot, easily irritated



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Epworth Sleepiness Scale

Patient Name: _____

Today's Date: _____

Patient Age: _____ Gender: _____

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 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 television.

3. Sitting inactive in a public place. (ex: doctor's office)

4. As a passenger in a car for an hour without a break.

5. Lying down to rest in the afternoon when possible.

6. Sitting and talking to someone.

7. Sitting quietly after lunch without alcohol.

8. In a car, while stopped for a few minutes in traffic.

Total Score: _____