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Patient General Health Questionnaire

Patient Name: _____ Date of Birth: _____Sex: M / F

Height: _____ Weight: _____ Weight last year: _____ Waist: _____ Neck Size: _____

Emergency Contact:_____Phone: _____Relation: _____

Check any of the following symptoms you have had in the past 12 months:

Yes	*No*		*Yes*	*No*	
□	□	Frequent headaches	□	□	Frequent heartburn
□	□	Fainting	□	□	Indigestion
□	□	Passing out	□	□	Abdominal pain
□	□	Sudden loss of vision or strength	□	□	Frequent constipation
□	□	Inability to speak	□	□	Frequent diarrhea
□	□	Hearing loss or ringing in ears	□	□	Rectal bleeding
□	□	Black Stools	□	□	Urinary Incontinence
□	□	Hoarseness for more than 2-4 weeks	□	□	Difficulty urinating
□	□	Nosebleeds	□	□	Blood in urine
□	□	Cough for more than 2-4 weeks	□	□	Urinating more than twice a night
□	□	Coughing up blood	□	□	Pain in joints or bones
□	□	Shortness of breath or wheezing	□	□	Unusual bruising or bleeding
□	□	Wheezing	□	□	Swelling in feet or ankles
□	□	Epilepsy	□	□	Seizures
□	□	Chest pain, tightness or pressure	□	□	Change in wart, mole or skin
□	□	Irregular or sudden, fast heartbeat	□	□	Weight loss of more than 5 lbs.
□	□	Difficulty swallowing or food “sticking”		□	Other: _____

Past Medical History

□ Hypertension (High Blood Pressure)	□ Hepatitis	□ Jaundice
□ Heart Disease	□ Hearing Impairment	□ Diabetes
□ Depression	□ Anxiety	□ Fibromyalgia
□ Chemical dependency or abuse	□ Alcoholism	□ Reflux
□ Lung problems	□ COPD	□ Asthma
□ Stroke	□ TIA "Light Stroke"	□ Blackouts
□ Seizures	□ Cancer	□ Thyroid problems
□ Stomach or colon problems	□ Back or joint problems (arthritis)	

□ Other: _____

Female □ Premenstrual Syndrome □ Menopause □ Other:_____

Male □ Prostate problems □ Erectile dysfunction/impotence □ Other:_____

Family History

Has an immediate blood relative had any of the following?

Yes	***No***	***Relation***	***Yes***	***No***	***Relation***
□	□ Cancer	_____	□	□ Stroke	_____
□	□ Diabetes	_____	□	□ Anxiety	_____
□	□ Hypertension	_____	□	□ Sleep Apnea	_____
□	□ Heart Disease	_____	□	□ Narcolepsy	_____
□	□ Thyroid Disease	_____	□	□ Other	_____

Current Medications	**Reason**	**How Long have you been taking**

Epworth Sleepiness Scale

Use the following scale to select the most appropriate number for the situation

0*= would never doze* ***2****=moderate chance of dozing* ***1****=slight chance of dozing* ***3****=high chance of dozing*

Sitting and reading ----------	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 afternoon when permitted----------	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
Watching TV----------	0	1	2	3

With the help of a bed partner please circle one of the following as it applies to a typical night.

Snoring	□ Nightly	□ Weekly	□ Rarely	□ Never
Observed pauses in breath	□ Nightly	□ Weekly	□ Rarely	□ Never
Restless or interrupted sleep	□ Nightly	□ Weekly	□ Rarely	□ Never
Awaken short of breath gasps, or snorts	□ Nightly	□ Weekly	□ Rarely	□ Never
Awaken coughing	□ Nightly	□ Weekly	□ Rarely	□ Never
Difficulty falling asleep	□ Nightly	□ Weekly	□ Rarely	□ Never
Leg or body jerks	□ Nightly	□ Weekly	□ Rarely	□ Never
Teeth grinding	□ Nightly	□ Weekly	□ Rarely	□ Never
Vivid dreams	□ Nightly	□ Weekly	□ Rarely	□ Never
Headache	□ Nightly	□ Weekly	□ Rarely	□ Never
Acid indigestion	□ Nightly	□ Weekly	□ Rarely	□ Never
Night sweats	□ Nightly	□ Weekly	□ Rarely	□ Never
Heart palpitations	□ Nightly	□ Weekly	□ Rarely	□ Never
Night time urination	□ Nightly	□ Weekly	□ Rarely	□ Never
Refreshed with morning wake up	□ Yes	□ No		
Dry mouth in morning wake up	□ Yes	□ No		
Sore jaw with morning wake up	□ Yes	□ No		

To the best of my knowledge all of the above information is true and correct.

_____ _____

Patient's Signature Date