



A. Asmi, MD

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Tel: (248) 681-7909

Waterford, MI 48328  
Fax: (248) 681-0455

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Date: \_\_\_\_\_

Hospitalizations in the past 12 months? Yes No Where \_\_\_\_\_

**Pulmonary History:**

Have you ever been diagnosed with a lung disease? Yes No (circle below)

If so, when \_\_\_\_\_ where \_\_\_\_\_

- Emphysema                      Chronic Bronchitis      COPD                      Asthma                      Sarcoidosis
- Pneumonia                      Lung Cancer

When was your last chest xray? \_\_\_\_\_ last ct scan chest? \_\_\_\_\_ last breathing test? \_\_\_\_\_

Do you have Shortness of Breath? Yes No How long? \_\_\_\_\_

What triggers your shortness of breath? (Circle) Hills, Stairs, Walking, Running, Any Exertion

Do you have a cough? Yes No

Do you bring anything up with the cough? Yes No

What color is it? \_\_\_\_\_

Do you cough up any blood? Yes No How much? \_\_\_\_\_ How Long? \_\_\_\_\_

Do you have any wheezing? Yes No

Do you have chest pain? Yes No

Do you have rib pain (pleuritic)? Yes No

Do you have palpitations? Yes No

Do you have any sinus problems? Yes No

Do you have any allergy problems? Yes No

Do you have leg swelling? Yes No

Do you have problems with fatigue? Yes No

Have you ever been exposed to any asbestos or pulmonary hazards in the past? Yes No

Are you using oxygen therapy or nebulizer machine? Yes No DME Company \_\_\_\_\_

**Sleep History:**

Have you ever been diagnosed with a sleep disorder? Yes No

If so, when \_\_\_\_\_ where \_\_\_\_\_

Have you ever been told that you snore? Yes No

Have you ever been told that you stop breathing? Yes No

Do you have daytime sleepiness? Yes No

Do you have Insomnia? Yes No

What time do you go to bed? \_\_\_\_\_

What time do you wake up? \_\_\_\_\_

How long does it take you to go to sleep? \_\_\_\_\_ Minutes Hours

Do you have any interruptions while sleeping? Yes No How many? \_\_\_\_\_

Do you wake up with an alarm or spontaneously? Do you feel refreshed? Yes No

Do you take any naps? Yes No

How many naps do you take \_\_\_\_\_ per day/week?

Does your naps feel refreshed? Yes No

**Do you have any of the following? (Circle)**

- |                      |                          |                        |                   |               |               |
|----------------------|--------------------------|------------------------|-------------------|---------------|---------------|
| Drowsy while driving | Dry Mouth                | Morning Headaches      | Acting out dreams | Night terrors | Sleep Talking |
| Sleep Paralysis      | Hallucinations           | Cataplexy              | Seizures          | Night Sweats  | Sleep Eating  |
| Restless leg         | Tossing / Turning in bed | Leg Cramps / Twitching | Nightmares        | Sleep Walking | Bedwetting    |



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**Personal & Social History:**

Occupation: Full Time Part Time Retired Unemployed  
 Marital Status: M, S, W, D Who do you live with? \_\_\_\_\_  
 Smoking: Previous Smoker Current Smoker Never Smoked  
 (Circle which type) Cigarettes Pipe Cigars  
 How many years did you smoke for? \_\_\_\_\_ How may packs per day? \_\_\_\_\_  
 How many years has it been since you quit? \_\_\_\_\_  
 Alcohol: Yes No Socially Heavy Drinker  
 Do you drink caffeine? Yes No How many cups per day? \_\_\_\_\_  
 Do you do any recreational drugs? Yes No  
 Do you exercise: Yes No  
 Do you have any animals? Yes No What kind of animal(s) do you have? \_\_\_\_\_  
 Have you had any weight changes? Increased or Decreased and how many pounds? \_\_\_\_\_  
 Do you have any hobbies? \_\_\_\_\_

**Family History:**

Father: Alive/Deceased, age \_\_\_\_\_ Any health problems? \_\_\_\_\_  
 Mother: Alive/Deceased, age \_\_\_\_\_ Any health problems? \_\_\_\_\_  
 Brothers: How many \_\_\_\_\_ Any health problems? \_\_\_\_\_  
 Sisters: How many \_\_\_\_\_ Any health problems? \_\_\_\_\_  
 Any Children: Sons \_\_\_\_\_ Daughters \_\_\_\_\_ Any health problems? \_\_\_\_\_

**Past Medical History:**

Have you ever had any of the following?(Circle)

- |                     |                    |                     |                 |
|---------------------|--------------------|---------------------|-----------------|
| Stroke              | Brain Tumor        | Headaches           | Seizures        |
| High Blood Pressure | Heart Problems     | Gerd                | Hernia          |
| Ulcer               | Bowel Obstructions | Intestinal Problems | Kidney Problems |
| Bladder Problems    | Prostate Problems  | Psoriasis           | Eczema          |
| Skin Cancer         | Thyroid            | Diabetes            | Anemia          |
| Leukemia            | AIDS               | Hepatitis           | Depression      |
| Bipolar             | Schizophrenia      | Anxiety             | Panic Disorder  |
| OCD                 | Mood Swings        |                     |                 |

**List your surgeries:**

- |          |          |
|----------|----------|
| 1. _____ | 4. _____ |
| 2. _____ | 5. _____ |
| 3. _____ | 6. _____ |