SUDHA KARUPAIAH, M.D.
INTERNAL MEDICINE & SLEEP DISORDERS

Name: _____
Birthdate: _____ Sex: _____
Age: _____ Date: _____

CONFIDENTIAL MEDICAL HISTORY

This questionnaire will help your doctor understand more about you and your medical problems.

PLEASE ANSWER EACH QUESTION AS CORRECTLY AS YOU CAN BY PLACING AN "X" IN APPROPRIATE BOX

WHAT IS THE **MAIN** REASON YOU ARE HAVING THIS EXAMINATION?

☐ (1) You are feeling ill or want medical advice. Describe your problem(s):

☐ (2) Sleep related Issues

☐ (3) Routine Checkup – No special Complaints

_____

_____

_____

IN THE LAST **3 MONTHS** HAVE YOU HAD ANY OF THE FOLLOWING PROBLEMS:

	YES	NO
Frequent or severe headaches……	□	□
Problems related to Ear/Nose/Throat……	□	□
Heart Problems……	□	□
Problems related to GI Tract……	□	□

	YES	NO
Unexplained weight loss (> 5 lbs in 3 mos)……	□	□
Allergies such as Hay Fever/Asthma……	□	□
Problems related to kidneys……	□	□
Other_____		

CHECK HERE ☐ IF NONE OF THE ABOVE

	YES	NO
Are you concerned that you may be at risk for developing sexually transmitted diseases? ……	□	□
Do you have a loss of sexual interest or difficulty in performance that concern you? ……	□	□
Do you have trouble sleeping? …… ***(if yes, please complete Sleep Questionnaire below)***	□	□

	YES	NO
Nervous, depressed or emotional trouble……	□	□
Are you now receiving care from a Psychologist or Psychiatrist? ……	□	□
In the past year has there been a death in your Immediate family?……	□	□

SLEEP QUESTIONNAIRE

	YES	NO	OCCASIONALLY
Do you have difficulty falling asleep?	_____	_____	_____
Do you wake up during the night?	_____	_____	_____
Do you have discomfort in your legs when laying down?	_____	_____	_____
Do you snore?	_____	_____	_____
Do you awaken with a choking sensation?	_____	_____	_____
Have you been told that you stop breathing when you are asleep?	_____	_____	_____
Are you excessively tired during the day?	_____	_____	_____

How likely are you to fall asleep during the day in the following situations?
(0 = would never doze / 1 = slight chance / 2 = moderate chance / 3 = high chance)

Situation	**Chance of Falling Asleep**				
Sitting and reading	**0**	**1**	**2**	**3**	
Watching TV	**0**	**1**	**2**	**3**	
Sitting inactive in a public place (movie 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 during the day when circumstances permit	**0**	**1**	**2**	**3**	
Sitting and talking to someone	**0**	**1**	**2**	**3**	
While in a car that is stopped	**0**	**1**	**2**	**3**	
Sitting quietly after lunch without alcohol	**0**	**1**	**2**	**3**	**SCORE: _____**

Please list your current medications and dosages: _____

Drug Allergies (please list) _____

OPERATIONS (please list when/year): _____

HAVE YOU RECEIVED PNEUMOVAX VACCINE (to prevent pneumonia) □ YES If so, when? _____ □ NO

PAST MEDICAL HISTORY:

HAS A DOCTOR EVER SAID YOU HAD ANY OF THE DISEASES OR CONDITIONS LISTED BELOW? (circle all that apply)

Arthritis	Epilepsy	Heart Disease
Stroke	Lung Disease	Gastrointestinal Diseases
Kidney Disease	Venereal Disease	Anemia
Cancer or Tumor	Diabetes	Gout
Thyroid Disease	Other: _____	

CHECK HERE □ IF **NONE** OF THE ABOVE

FOR WOMEN ONLY:

	YES	NO
Menopause ……	□	□
Vaginal discharge with burning or itching……	□	□
Lump in breast not previously operated on…….	□	□
Are you now pregnant?.....	□	□
Have you ever been pregnant? …….	□	□

If yes, How many children do you have? _____

How many miscarriages or abortions? _____

Do you take birth control pills? ……. □ □

When did you have your last pap test? _____

FAMILY HISTORY

IF ANY IMMEDIATE BLOOD RELATIVES HAVE HAD ANY OF THESE CONDITONS PLEASE CHECK WHO.

Condition	Father	Mother	Brother or Sister	Son or Daughter
Sleep Apnea				
Cancer Which part of body?				
Diabetes				
Heart disease • Heart attack • High blood pressure				
Suicide or mental illness				
Stroke				
Other conditions not listed above that run in your family				

Sister and Brothers:
How many have you had? _____
If any are deceased, give age and cause of death:

Age	Cause of Death
_____	_____
_____	_____
_____	_____

Parents:
If any are deceased, give age and cause of death:

Age	Cause of Death
_____	_____
_____	_____

PERSONAL HISTORY

Where were you born: _____ Marital Status: _____

Do you have children? Yes □ No □ How many? _____ What are their ages? _____

ARE YOU NOW HAVING SERIOUS OR DISTURBING PROBLEMS WITH YOUR:

( ) Marriage ( ) Family ( ) Drugs ( ) Job or employment ( ) Financial matters ( ) Other worries

Occupation: _____

HABITS

Have you ever smoked cigarettes? Yes □ No □ How many packs a day? _____
Have you smoked cigarettes in the last ten (10 Years)? Yes □ No □ How long have you smoked? _____
Are you still smoking? _____ Yes □ No □ If not, when did you quit? _____

In the past year did you drink alcohol? Yes □ No □ Do you think you drink too much alcohol? Yes □ No □
Have you ever had a drinking problem for which you received treatment or which you got over by yourself? Yes □ No □

Do you exercise regularly? Yes □ No □ Do you use recreational drugs? Yes □ No □
If yes, what kind? _____