**Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date of Birth:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Section 1: ID Risk Screen**

 No Travel History Last 7 Days Last 14 Days Last 21 Days Last 2 Months

Recent Travel Location: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Family Member/Household/Contact Travel History

 No Travel History Last 7 Days Last 14 Days Last 21 Days Last 2 Months

Recent Travel Location: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*Contact with person with highly contagious disease (Ebola/MERS/2019-nCoV) AND have one or more of the systems below: Yes No

\*Travel to a country with wide-spread (Ebola/MERS/2019-nCoV) in the past 21 days AND have one or more of the systems below: Yes No

*Ebola Symptoms: Fever, Headache, Weakness, Muscle Pain, Vomiting, diarrhea, Abdominal Pain or Hemorrhage*

*MERS (Middle East Respiratory Syndrome) Symptoms: Fever, Chills/Rigors, Headache, Sore Throat, Cough, Difficulty Breathing, Nausea, Vomiting, Diarrhea, Abdominal Pain or Muscle Pain*

*Zika Symptoms: Macular or Papular Rash, Fever, Arthralgia or Conjunctivitis*

*Some symptoms are not unique for TB. For new or worsening cough, provide patient with a mask.*

*2019-nCov (2019-nCoV Novel Coronavirus) Symptoms: Fever and symptoms of lower respiratory illness (e.g., cough, difficulty breathing)*

Infectious Disease Risk Factors/Symptoms—*(Only if YOU or FAMILY MEMBER has traveled)*

|  |  |  |
| --- | --- | --- |
|  | **Yes** | **No** |
| **Vomiting** |  |  |
| **Diarrhea** |  |  |
| **Abdominal(Stomach Pain)** |  |  |
| **Weakness/Numbness** |  |  |
| **Exposure to Disease** |  |  |
| **Abnormal Breathing** |  |  |
| **Unexplained bruising** |  |  |
| **Joint Pain** |  |  |
| **Abscess** |  |  |
| **Rash** |  |  |

|  |  |  |
| --- | --- | --- |
|  | **Yes** | **No** |
| **Chills** |  |  |
| **Fever** |  |  |
| **Fatigue** |  |  |
| **Headache** |  |  |
| **Runny or Stuffy Nose** |  |  |
| **Sore Throat** |  |  |
| **Difficulty Breathing** |  |  |
| **Shortness of Breath** |  |  |
| **New or Worsening Cough** |  |  |
| **Wheezing** |  |  |

MDRO History Surveillance

|  |  |  |
| --- | --- | --- |
|  | **Yes** | **No** |
| **History of Clostridium Difficile** |  |  |
| **History of Extended Spectrum beta-Lactamase** |  |  |
| **History of MRSA** |  |  |
| **History of Vancomycin-resistant enterococci** |  |  |
| **History of Carbapenem-resistant Enterobacteriaceae** |  |  |
| **Other** |  |  |

 Verify droplet, Contact Isolation for Ebola : Yes N/A

\*Verify Airborne, Contact Isolation for MERS/2019-CoV: Yes N/A

Does the Patient Have any of the Following Conditions That Compromise the Immune System

|  |  |
| --- | --- |
| ○ None○ Acquired immune deficiency syndrome (AIDS)○ AIDS related complex (ARC)○ Any immunodeficiency syndrome○ Chronic Lymphocytic Leukemia (CLL)○ Congenital or hereditary immunodeficiency○ Human Immunodeficiency Virus (HIV)○ Leukemia within 90 days ○ Lymphocytic Leukemia within 90 days○ Marked Neutropenia within 90 days○ Myelodysplasia within 90 days | ○ Myelogenic Leukemia within 90 days○ Organ Transplant○ Pancytopenia within 90 days○ Prior hospitalization within 14 days○ Radiation therapy within 90 days○ Significant neutropenia within 90 days○ Systemic chemotherapy within 90 days○ Systemic corticosteroid/Prednisone therapy within 90 days○ Systemic immunosuppressive therapy within 90 days |

**Section 2: Summary**

Chief Complaint: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Neck Circumference: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_inches

Onset of Symptoms: ­­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Additional Information: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Preferred Language: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Method of Arrival: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Arrived With: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Consent Signed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Onset of Symptoms: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Last Menstrual Period: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Vitals:

BP: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ BP site: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ HR: \_\_\_\_\_\_\_\_\_\_\_ HR Site: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Temp: \_\_\_\_\_\_\_\_\_\_\_\_­­\_ Site: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ RR: \_\_\_\_\_\_\_\_\_ SpO2 %: \_\_\_\_\_\_\_\_\_\_\_\_\_ O2: \_\_\_\_\_\_\_\_\_\_

Measurements:

Height: \_\_\_\_\_\_\_\_\_\_\_\_in/cm Weight: \_\_\_\_\_\_\_\_\_\_\_\_lb/kg Method Weight Obtained: \_\_\_\_\_\_\_\_\_\_\_\_

Head Circumference: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ cm Chest Circumference: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ cm

Abdominal Circumference: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ cm

**Section 3: Problems and Visit Diagnosis: Any changes from your previous visit?**

*Diagnosis*: Why are you being seen today? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Past Medical History:

|  |  |
| --- | --- |
| **Date** | **Problem** |
|  |  |
|  |  |

**Section 4: Medications/Allergies: Any changes from your previous visit?**



 

**Section 5: Procedures/Surgeries: Any changes from your previous visit?**

|  |
| --- |
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Anesthesia and Transfusions:



**Section 6: Family History: Any changes from your previous visit?**

|  |
| --- |
|  |
|  |
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|  |

**Section 7: History**

Have you been hospitalized outside the US in past 6 months? Yes No

 Patient shows signs/symptoms of neglect? Yes No

History Assessed: Yes No

Have you used Tobacco anytime during the past 30 days? Yes No

Alcohol Use: Current Past Never

Type: Beer Wine Liquor Other:

Frequency: 1-2 x year 1-2 x month 1-2 x week 3-5 x week Daily Several x Day

Tobacco Use:

 Current Status unknown Unknown if ever smoked Current every day smoker

 Current some day smoker Former smoker Never smoker

 Heavy tobacco smoker Light tobacco smoker

Electronic Cigarette Use:

 Never Use, within 90 days Former use, greater than 90 days

 Refused screening Unknown/Not Obtained Other

Type: ­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Uses/Inhales per day: ­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Substance Use: Current Past Never

Type: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Section 8: Morse Fall Risk**

History of Falling Immediate or Within Last 3 Months: Yes No

Presence of Secondary Diagnosis: Yes No

Use of Ambulatory Aid: Furniture Crutches, cane, walker None, bedrest, wheelchair

IV/Heparin Lock: Yes No

Gait/Transferring: Impaired Weak Normal, bedrest, immobile

Mental Status: Forgets Limitations Oriented to own ability

**Section 9: Advance Directives**

Advance Directives: Yes No

Patient Wishes to Receive Further Information on Advance Directives: Yes No

**Section 10: Health Status**



Immunizations Current: Yes  No  Non Received  Unknown  Vaccine Recommended

* Other





**Section 11: Adult Depression Screening**

**Complete if 12 years old or younger**

**PHQ2-PHQ9 Screening:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Over the past 2 weeks, how often have you been bothered by any of the following problems? | Not At All | Several Days | More than ½ the Days | Nearly Every Day |
| 1. Little interest or pleasure in doing things:
 | 0 | 1 | 2 | 3 |
| 1. Feeling down, depressed or hopeless:
 | 0 | 1 | 2 | 3 |
| **If you answered 0 to the questions above- stop**  |
| 1. Trouble falling asleep, staying asleep or sleeping too much:
 | 0 | 1 | 2 | 3 |
| 1. Feeling tired or having little energy:
 | 0 | 1 | 2 | 3 |
| 1. Poor appetite or overeating:
 | 0 | 1 | 2 | 3 |
| 1. Feeling bad about yourself:
 | 0 | 1 | 2 | 3 |
| 1. Trouble concentrating:
 | 0 | 1 | 2 | 3 |
| 1. Moving or speaking so slowly:
 | 0 | 1 | 2 | 3 |
| 1. Thoughts that you would be better off dead or of hurting yourself in some way:
 | 0 | 1 | 2 | 3 |
| 1. Difficulty at work, home, or getting along with others:
 | 0 | 1 | 2 | 3 |
| Column Totals: |  |  |  |  |
| Add Totals Together: |
| 1. If you checked off any problems, how difficult have those problems made it for you to do your work, take care of things at home, or get along with other people?

 Not Difficult at all Somewhat Difficult Very Difficult Extremely Difficult |

**Pediatric Questionnaire - Sleep Clinic**

Please completely fill in the circles which best describe your current condition. Please answer all questions. Thank you

**Pulmonary:**

Shortness of breath at rest

Shortness of breath with exercise

Frequent cough

Coughing up blood

Chest pain

Wake up at night short of breath

Recurrent chest infections

Exposure to tuberculosis

Wheezing

Blood clot in legs or lungs

**Cardiac:**

High blood pressure

Heart attack

Leg swelling

Heart racing or thumping

Rheumatic fever

Needs to sleep on 2 or more pillows

High cholesterol

**Constitutional symptoms:**

Fever

Night sweats

Chills

Weight loss

**Musculoskeletal:**Muscle weakness
Joint pain
Joint swelling

**Psychiatric:**Depression
Anxiety
Poor sleep
Snoring
Morning headaches or awakening
Excessive sleep during day
Panic attacks

No

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**Gastrointestinal:**

Trouble swallowing

Choking on food

Heartburn

Abdominal pain

Nausea

Vomiting

Diarrhea

Ulcers

Jaundice

**Renal:**

Blood in urine

Urinary tract infections

Kidney stones

Frequent urination at night

Painful urination

**Neurologic:**

Stroke

Migraines

Frequent headaches

Numbness or tingling

Seizure

Dizziness

Imbalance or unsteadiness

Vertigo

**Hematology/Oncologic:**
Anemia
Cancer
Bleeding tendency
Blood transfusion

**ENT:**
Blurred vision
Decreased hearing
Frequent sore throat
Sinus infections
Hay fever
Hoarseness

Yes

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**PEDIATRIC SLEEP HISTORY**

This questionnaire will provide the Sleep Disorders Program with a better understanding about your child's case. Please answer all questions to the best of your ability. If any questions are not applicable please leave them blank.

1. Child's usual bedtime on weeknights: am/pm
2. Child's usual wake time on weekdays: am/pm
3. Child's usual bedtime on weekends: am/pm
4. Child's usual wake time on weekends: am/pm
5. On average, how many hours does your child sleep per night? hours
6. How long does it usually take your child to fall asleep? minutes
7. Under usual circumstances, how often does your child awaken during the night: times per night
8. Does your child return to sleep without assistance after waking at night? yes/no
9. Does your child awaken too early and have difficulty going back to sleep? yes/no If "yes" estimate how many times per week: times per week
10. Does your child fall asleep alone in his/her own bed? yes/no
11. Does your child need someone in the room to fall asleep? yes/no
12. Does your child need a special object to fall asleep? yes/no
13. Does your child go to bed without a struggle? yes/no
14. Is your child afraid to sleep in the dark? yes/no
15. How long has your child experienced sleep problems? months
16. Does your child snore? yes/no If "yes" estimate how long: months
17. Does your child grind his/her teeth during sleep? yes/no If "yes" estimate how long: months
18. Does your child get up in the night to use the restroom? yes/no
19. Does your child stop breathing during sleep? yes/no
20. Does your child complain of awakening with a sensation of choking during the night? yes/no
21. Does your child breath with his/her mouth open while sleeping? yes/no
22. Does your child's arms and legs jerk during sleep? yes/no
23. Does your child sleep walk? yes/no
24. Does your child talk during sleep? yes/no
25. Does your child complain of body pain during sleep? yes/no If "yes" what type? type
26. Does your child usually seem rested when he/she wakes up? yes/no
27. Does your child usually wake up by him/herself? yes/no
28. Does your child have difficulty getting up in the morning? yes/no
29. How long does it usually take for your child to become alert in the morning? minutes
30. Does your child feel sleepy during the day? yes/no
31. How long has daytime sleepiness been a problem for your child? months
32. Does your child usually take naps during the day? yes/no
33. Does your child usually seem tired? yes/no
34. Does sleepiness interfere with your child's normal work/school performance? (Include his/her job and/or home activities) yes/no
35. Does sleepiness interfere with your child's normal social activities with family, friends, or other groups? yes/no
36. Has your child had accidents or near accidents because of sleepiness? yes/no
37. Have you ever been told that a family member has a sleep disorder? yes/no Type of sleep disorder:
38. When your child is angry, laughing, or frightened, does he/she complain of feeling weak as though he/she might fall? yes/no
39. Does your child remember dreams? yes/no
40. Does your child have nightmares? yes/no If "yes" estimate how many per week: per week
41. Does your child ever wake up screaming/yelling from a nightmare? yes/no If "yes" estimate how many times per week: per week
42. When your child falls asleep or just before he/she wakes up does he/she:
	1. Have bizarre dreams? yes/no
	2. Feel as if he/she is paralyzed? yes/no
43. Does your child have difficulty concentrating? yes/no
44. Has your child recently had problems with memory/attention to detail? yes/no
45. Have you noticed a difference in your child's personality in the last six months? yes/no
46. Does your child feel stressed? yes/no
47. Does your child experience anxiety? yes/no
48. Does your child ever seem irritable? yes/no
49. Has your child recently felt depressed? yes/no
50. Does your child have any behavioral problems? yes/no
51. Does your child have headaches? yes/no
52. Does your child have any allergies? yes/no
53. Has your child been diagnosed with ADHD/ADD yes/no
54. Does your child have speech problems? yes/no
55. Does your child have difficulty swallowing? yes/no
56. Has your child had his/her tonsils removed? yes/no
57. Does your child have thyroid disease? yes/no
58. Does your child have asthma? yes/no
59. Does your child have diabetes? yes/no
60. Does your child have difficulty breathing? yes/no
61. Does your child have any nasal/sinus problems? yes/no
62. Has your child ever had surgery on his/her sinuses for a sleep disorder? yes/no
63. Does your child have heartburn (acid reflux)? yes/no
64. Does your child have any neurological disorders? yes/no
65. Does your child have any neuromuscular diseases? yes/no
66. Does your child have a history of seizures? yes/no
67. Has your child had a traumatic brain injury/concussion? yes/no
68. Has your child had a spinal cord/neck injury? yes/no
69. Does your child wet the bed? yes/no
70. Does your child have any facial abnormalities? yes/no
71. Does your child drink caffeinated beverages? yes/no If "yes" estimate how many glasses, cups, or cans per day: per day
72. Has your child previously been diagnosed with a sleep disorder? yes/no
73. Has your child ever had surgery, taken medications, or received other treatment for sleep-related problems in the past? yes/no

**IF "YES" PLEASE ANSWER QUESTIONS 77-80**

**IF "NO" PLEASE SKIP TO QUESTION 81**

1. Is your child taking medications for his/her sleep problems? yes/no If "yes" please list
2. Does your child ever use an oxygen aid while sleeping? yes/no
3. Does your child use nasal CPAP or BIPAP for sleep apnea? yes/no
4. If "yes" does he/she feel any different when using CPAP or BIPAP? yes/no If "yes" in what way?
5. Do you have any major concerns regarding your child's physical or emotional well-being or overall health due to sleep problems? yes/no
6. Does your child enjoy sleep? yes/no
7. Does he/she like to sleep late whenever he/she can? yes/no

Please use the following space to comment on anything else you would like us to know about your child's medical or sleep problems.

Parent\Guardian Initials: \_\_\_\_\_\_\_\_