Sleep Disorder Center
of Panama City
502 N. MacArthur Avenue
Panama City, Florida 32401

Patient Information

Patient Name: ____ Sex: ______
Last First MI

Date of Birth: ________________________Age: _____ SSN: ___________________

Mailing Address: ____

City: ______________________________ State: ___________ Zip: ____________

Home Phone: ___________________________ Cell Phone: ____________________

Marital Status: S ☐M ☐D ☐ W ☐ Employer: ______________________________

Emergency Contact

Notify: ________________________________ Relationship: ___________________

Home Number: (_____) __________________ Cell Phone: (_____) ______________

Insurance Information

Primary Insurance: ____

Policy Number: ____________________________ Group Number: ______________

Sponsors Name (if not patient): ___________________________ DOB: ___________

Sponsors SSN: (if not patient): ____

Secondary Insurance: ____

Policy Number: ____________________________ Group Number: ______________

Sponsors Name (if not patient): ___________________________ DOB: ___________

Sponsors SSN: (if not patient): ____

Signature: _______________________________ Date: __________________

Patient Questionnaire

Referring Physician: ______________________________
Family Physician: ________________________________

My main sleep complaints: Check the appropriate Box ☐

☐ Trouble sleeping at night For how many months/years? __________
☐ Being sleepy during the day For how many months/years? __________
☐ Snoring For how many months/years? __________
☐ Odd or violent behaviors during sleep, explain: _____________________________________
____
Other:

Are you unable to sleep on your back due to shortness of breath? Y ☐ N ☐
Have you ever had a brain concussion, head injury or serious blow to the head? Y ☐ N ☐
Do you have seizures or spells? Y ☐ N ☐
Not including your primary care physician or referring doctor, have you seen another doctor for your sleep problem? Y ☐ N ☐
If yes, who and when were you seen? ____
____
If yes, what was the diagnosis? ____

Previous NPSG

Have you ever had a sleep study before? Y ☐ N ☐
If yes, when and where? ____
What treatment, if any, was recommended? ____
Was the treatment effective? Y ☐ N ☐

Have you had any surgeries related to sleep disorders? Y ☐ N ☐
If yes, what kind? ____
When? _______________ Physician? ____

If you are currently using the following, please fill in blanks if known.

CPAP Pressure: ________cmH2O
BiPAP Pressure: _________cmH2O
Oxygen: _______LPM

If you use this equipment, what company provides you services

____

Medical History

Please check all the appropriate BOXES ☐ IF you have any of the below condition in the present or in the past.

☐ Heart Disease	☐ Cancer	☐ Muscular dystrophy
☐ Seizures	☐ Prostate Trouble	☐ ADHD
☐ Heartburn	☐ Fibromyalgia	☐ Renal Failure
☐ Hiatal Hernia	☐ Rheumatoid Arthritis	☐ Rest Leg Syndrome
☐ Impotence	☐ High Blood Pressure	☐ Diabetes
☐ Bladder Trouble	☐ Mental Problems	☐ Thyroid Problems
☐ Ringing in Ears	☐ Dementia	☐ Anemia
☐ Eye Trouble	☐ Bipolar Disorder	☐ Head Injury
☐ Kidney Trouble/Disease	☐ General Anxiety	☐ Brain Surgery
☐ Headaches/Migraines	☐ Panic Disorder	☐ Emphysema
☐ Gout	☐ Back Pain	☐ Anxiety Disorder
☐ Dizziness	☐ Use of Narcotics	☐ High Cholesterol
☐ Epilepsy	☐ Low Blood Pressure	☐ Depression/Bipolar
☐ Fibromyalgia	☐ Tuberculosis	☐ Stroke/TIA
☐ Asthma or COPD	☐ Muscle Cramp	☐ Coronary Artery Disease
☐ Otitis or Tonsillitis	☐ Arthritis	☐ Cataracts
☐ Pneumonia	☐ Allergies	☐ Chronic Nasal Congestion
☐ Bronchitis	☐ Sleep Disorders	☐ Nose / Sinus Surgery
☐ Hemophilia (Bleeder)	☐ Snoring	☐ Neuropathy
☐ Meningitis	☐ Parkinson Disease	☐ A fib
☐ Syncope/Fainting	☐ Muscle Disease	☐ Myasthenia Gravis
☐ Esophageal or stomach ulcer	☐ MS	
☐ Sleep Walking	☐ Heart Attack	

Check any of the following symptoms you have to an excessive degree.

☐ Fatigue ☐ Depression ☐ Memory Impairment
☐ Inability to Concentrate ☐ Change in Personality ☐ Irritability
☐ Anxiety ☐ Family Problems ☐ Loss of appetite

Have you had your tonsils removed? N ☐ Y ☐ At what age? ________
Have you had nose and/or throat surgery? N ☐ Y ☐ At what age? ________

Please list any other surgeries and/or hospitalizations you have had:

Date Reason

____
____
____
____

(If more space is needed, please continue on the back of this sheet.)

Do you have any allergies?
If yes, please specify: ____

Family History

Please check all that apply to your family (past or present conditions).

	Father	Mother	Siblings	Children
Cancer:	☐	☐	☐	☐
Depression:	☐	☐	☐	☐
Diabetes:	☐	☐	☐	☐
Heart Disease:	☐	☐	☐	☐
High Blood Pressure:	☐	☐	☐	☐
Stroke:	☐	☐	☐	☐
Insomnia:	☐	☐	☐	☐
Narcolepsy:	☐	☐	☐	☐
Restless Legs:	☐	☐	☐	☐
Sleep Apnea:	☐	☐	☐	☐
Snoring:	☐	☐	☐	☐

Social History

Employment Status: ☐ Employed ☐ Unemployed ☐ Retired

☐ Yes ☐ No My job requires driving a vehicle

☐ Yes ☐ No I work with dangerous equipment or substances

☐ Yes ☐ No I am a shift worker on rotating shifts

☐ Yes ☐ No I am a permanent or long term night shift worker

☐ Yes ☐ No I am currently a student

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

☐ Yes Sleep alone in a bed ☐ No

☐ Yes Sleep in a chair ☐ No

☐ Yes Share a bed with someone ☐ No

☐ Yes Share a home, only ☐ No

Number of children______and ages: ____

Alcohol

Do you currently drink alcohol? Y ☐ N ☐

Do you have a drink prior to bed? Y ☐ N ☐

Do you have a history of alcohol abuse/chemical dependency? Y ☐ N ☐

Tobacco

Do you currently use tobacco products? Y ☐ Never ☐ Stopped ☐

If yes, choose: Pipe ☐ Cigarettes ☐ Cigars ☐ Other__________________

_______# daily for _____________months/years

Caffeine

Do you currently drink caffeinated beverages? Y ☐ N ☐

If yes, choose: Soft Drinks ☐ Coffee ☐ Tea ☐ Cocoa/Chocolate Milk ☐

____________# cups daily

Weight Status

Your current weight: ________ Height: ________ Neck: ________ BMI: _______
Are you on a diet? Y ☐ N ☐
What kind of diet? ____________________________________ For how long? _______________
Do you exercise? Y ☐ N ☐
If yes, what type(s) of exercise and how often? _______________________________________
____
____
Has your weight changed recently? Y ☐ N ☐
If yes, gain/loss of ___________________lbs over _______months/years

Mood

Do you feel depressed? Y ☐ N ☐
If yes, choose: Rarely ☐ Occasionally ☐ Frequently ☐
Has your family/friends commented about you being irritable? Y ☐ N ☐
Do you (or others) feel you have had a recent personality change? Y ☐ N ☐
If yes, specify: ____
____

Sleep Hygiene

On weekdays/workdays, what time do you:
Go to bed? _______a.m./p.m. Get up? _______a.m./p.m.
On weekends/days off, what time do you:
Go to bed? _______a.m./p.m. Get up? _______a.m./p.m.
Do you take naps during the day? Y ☐ N ☐
If yes, how many naps daily? __________
Are these naps refreshing? Y☐ N ☐
How long do the naps last? ______--__ minutes/hours
Do your children and/or pets sleep with you? Y☐ N ☐
If yes, specify:____

Insomnia

Do you have difficulty falling asleep? Y ☐N ☐
If yes, how long does it take? ________minutes/hour________# of nights weekly
Do you wake during the night? Y ☐ N ☐
If yes, _______# of times a night_______# of times weekly
Why do you awaken? ____
Do you have extended periods of wakefulness during the night? ☐Y N ☐
If yes, _______# of times a night ________# of times weekly
Do you awaken too early in the morning and stay awake? Y ☐ N ☐
If yes, _______# of times a night_______# of times weekly

Parasomnias

Do you currently:
Have intense nightmares? Y ☐ N ☐ ______________________________# of times per week
Walk in your sleep? Y ☐ N ☐ ____________________________________# of times per week
Grind or clinch your teeth at night? Y ☐ N ☐ ________________________# of times per week
Have incontinence of urine during sleep? Y ☐ N ☐___________________# of times per week
Talk in your sleep? Y ☐ N ☐ _____________________________________# of times per week

Hypersomnia

Are you sometimes drowsy while driving? Y ☐ N ☐
If yes, choose: Usually ☐ Occasionally ☐ Only on long trips____________________
Have you had an accident or near miss because of dozing while driving? Y ☐ N ☐
If yes, explain____

Epworth Scale

How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired? This questionnaire refers to your chance of falling asleep, according to your usual way of life, for about the last week or two. Even if you have not done some of these things recently, try to estimate how they would have affected you during the last two weeks.

Use the following scale to choose the most appropriate number for each situation:

Scale: 0 = **No** chance of dozing 1 = **Slight** chance of dozing 2 = **Moderate** chance of dozing 3 = **High** chance of dozing **Situation**	**Chance of Dozing**			
Sitting and reading	0 ☐	1 ☐	2 ☐	3 ☐
Watching TV	0 ☐	1 ☐	2 ☐	3 ☐
Sitting inactive in a public place (i.e.- in a theater or a meeting)	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 circumstances permit	0 ☐	1 ☐	2 ☐	3 ☐
Sitting and talking to someone	0 ☐	1 ☐	2 ☐	3 ☐
Sitting quietly after a lunch without alcohol	0 ☐	1 ☐	2 ☐	3 ☐
In a car, while stopped for a few minutes in traffic	0 ☐	1 ☐	2 ☐	3 ☐
Subtotal Epworth Score	+	+		
Total	=			

Scoring:
7 or less = You have a normal amount of sleepiness
8 to 9 = You have a average amount of sleepiness
10 to 15 = You may be excessively sleepy depending on the situation and you may want to seek medic al attention
16 + up = You are excessively sleepy and should seek medical attention

Narcolepsy

Have you ever felt sudden muscle weakness when you laughed, were angry, or surprised?
Y ☐ N ☐ If yes, describe: ____

____

Have you ever had vivid dreams as you were falling asleep or waking up? Y ☐ N ☐
If yes, describe: ____

____

Have you ever been unable to move or feel paralyzed as you were falling asleep or waking up?
Y ☐ N ☐ If yes, describe:

____

____

RLS/PLMS

Do you awaken at night by kicking your legs? Y ☐ N ☐
If yes, choose: Rarely ☐ Occasionally ☐ Frequently ☐
Has your bed partner ever complained of leg kicks? Y ☐ N ☐
If yes, choose: Rarely ☐ Occasionally ☐ Frequently ☐
Do you have a restless sense of discomfort in your legs while resting or before falling asleep?
Y ☐ N ☐ If yes, choose: Rarely ☐ Occasionally ☐ Frequently ☐

OSA

Do you awaken with a sore throat? Y ☐ N ☐ If yes
choose: Rarely ☐ Occasionally ☐ Frequently ☐
Do you awaken with nasal congestion? Y ☐ N ☐ If yes
choose: Rarely ☐ Occasionally ☐ Frequently ☐
Do you awaken with dry mouth? Y ☐ N ☐ If yes
choose: Rarely ☐ Occasionally ☐ Frequently ☐
Have you ever been told you stop breathing during sleep? Y ☐ N ☐ If yes
choose: Rarely ☐ Occasionally ☐ Frequently ☐
Do you ever awaken gasping for air? Y ☐ N ☐ If yes
choose: Rarely ☐ Occasionally ☐ Frequently ☐
Do you awaken with morning headaches? Y ☐ N ☐ If yes
choose: Rarely ☐ Occasionally ☐ Frequently ☐
Do you have problems with memory or concentration? Y ☐ N ☐ If yes
choose: Rarely ☐ Occasionally ☐ Frequently ☐
Do you feel unrefreshed after sleeping? Y ☐ N ☐ If yes
choose: Rarely ☐ Occasionally ☐ Frequently ☐
Do you have heartburn at night? Y ☐ N ☐ If yes
choose: Rarely ☐ Occasionally ☐ Frequently ☐
Do you have night sweats? Y ☐ N ☐ If yes
choose: Rarely ☐ Occasionally ☐ Frequently ☐

How many times do you awaken to urinate during the night? _______
Do you snore? Y ☐ N ☐ If yes, is it occasionally Y ☐ N ☐or continuously ☐Y ☐N
and is it only on your back Y ☐ N ☐ or in any position ☐Y ☐N

Using the scale below, rate your snoring:
☐ Grade 1: Heard only if you listen close to the face
☐ Grade 2: Heard inside the room
☐ Grade 3: Heard outside the bedroom with the door open
☐ Grade 4: Heard outside the bedroom with the door closed

Bed Partner Questionnaire

(The following is to be answered by someone that shares a bed with you.)

Check the below ☐ of the following behaviors that you have observed the patient doing while asleep.

Yes	No	Observed behavior
☐	☐	Light Snoring
☐	☐	Loud Snoring
☐	☐	Crying Out
☐	☐	Occasional loud snorts
☐	☐	Pauses in Breathing
☐	☐	Choking
☐	☐	Kicking of Legs
☐	☐	Jerking of Arms
☐	☐	Grinding Teeth

Yes	No	Behavior
☐	☐	Sleep Walking
☐	☐	Biting Tongue
☐	☐	Awakening with Pain
☐	☐	Head Rocking/Banging
☐	☐	Bed Wetting
☐	☐	Become Rigid or Shaking
☐	☐	Sitting up in bed but not awake
☐	☐	Eating while Sleep
☐	☐	Nightmares or Terrors

Other: ____

Has this person ever fallen asleep during normal daytime activities or in dangerous situations?
Y ☐ ☐No If yes, explain: ____
____
____

How Did You Hear About Us?

☐Print Advertising ☐Internet ☐ TV
☐ Radio ☐Friend/Family
☐Doctor Referral; If yes, which doctor? ________________________________

Medications

Preferred Pharmacy: ____

Please list all medications (OTC, vitamins, herbals, supplements, diet aids, prescribed)

Medication allergies: ____
____

Medication	Dose and Frequency	Dr Name