TALLAHASSEE SLEEP DIAGNOSTIC CENTER
PATIENT INFORMATION SHEET

DATE: _____ CHART #: _____

_____	_____	_____	_____/_____/_____
Last Name	First Name	M.I.	Date of Birth

(To be completed by TSDC staff)

_____	_____	_____	_____
Weight	Height	Blood Pressure	Pulse

Medications:	Dosage:	Times per day taken:	Doctor:
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____
4. _____	_____	_____	_____
5. _____	_____	_____	_____
6. _____	_____	_____	_____
7. _____	_____	_____	_____
8. _____	_____	_____	_____

(If additional space is needed for medications, please list on back of this sheet.)

ARE YOU ALLERGIC TO ANY DRUGS? YES / NO(circle one)if yes, please list below.

1. _____ 2. _____
3. _____ 4. _____

ANY OTHER ALLERGIES? YES / NO(CIRCLE ONE)if yes, please list below.

1. _____ 2. _____
3. _____ 4. _____

SLEEP HISTORY:

The information in this history is confidential and shall become part of your chart.

1. How do you describe your sleep problems? Check all that apply and list any other reasons you feel your sleep is disturbed.
   - (___) difficulty falling asleep
   - (___) wake up during night
   - (___) wake up too early
   - (___) excessive daytime sleep
   - (___) difficulty awakening

   Others: _____
2. Explain any family history of sleep problems.

   _____

   _____

   _____
3. List any current medical problems for which you are under a doctor's care:

   1. _____ 2. _____
   3. _____ 4. _____

(CIRCLE ONE)

4. Do you feel that your sleep disturbance affects your work or social life? Yes No
   If yes, explain: _____
   _____
5. Do you feel that your sleep disturbance affects you financially? Yes No
   If yes, explain: _____
   _____
6. Does your sleep problem require you to cut back on social activities? Yes No
7. Do you feel refreshed after sleeping at night? Yes No
8. Do you take naps daily? Yes No If yes, how many? _____
9. Do you feel refreshed after your nap? Yes No
10. Do you work rotating shifts? Yes No
    If you do work rotating shifts, give your schedule: _____
    _____

PLEASE DESCRIBE YOUR SLEEP PATTERN BY FILLING IN THE BLANKS:

1. It usually takes me _____ (min/hours) to fall asleep.
2. My sleep is generally disturbed by _____ (#) awakenings.
3. I feel the reason I am awakened is _____
   _____
4. I generally get _____ (#) hours of sleep per night.
5. On weekdays I go to bed at _____ (time) and wake up/get up at _____.
   On weekends I go to bed at _____ and wake up/get up at _____.
6. Do you do physical exercise before going to bed? Yes No
7. Do you consume any of the following within 4 hours of going to bed and if so, how much?
   Coffee Yes No How much? _____
   Tea Yes No How much? _____
   Alcohol Yes No How much? _____
   Soda Yes No How much? _____
   Over the counter drugs Yes No What? _____

On a scale from 1 – 10 rate the following: (1 = never, 10 = constantly, or any number between 1 – 10 that you feel helps explain your sleep history more accurately)

(1 – 10)

1. Do you snore? _____
2. Do you snore loudly enough that others complain? _____
3. Have you had apnea or breathing problems at night witnessed by others? _____
4. Do you awaken with shortness of breath or feel as if you are gasping for breath? _____
5. Do you sweat excessively during the night? _____

SLEEP SCALE – CONTINUED (1 – 10)

6. Do you have indigestion after going to bed? _____
7. Are you awakened by chest pain? _____
8. Do your legs feel uncomfortable and/or do you have the urge to move them before going to sleep? _____
9. Has your bed partner complained of kicking and jerking movements made by you during sleep? _____
10. Do you fall asleep involuntarily during the day? _____
11. Have you fallen asleep while driving? _____
12. Have you fallen asleep during physical effort or while laughing or crying? _____
13. Do you experience loss of muscle tone when you are extremely upset? _____
14. Do you feel unable to move when waking or falling asleep? _____
15. Do you have vivid dream-like scenes upon awakening or falling asleep? _____

REVIEW OF SYSTEMS

(This section relates to your medical history and is essential to us. Please complete fully.)

Eyes:

1. Do you ever have double vision? Yes No
2. Do you ever see spots, shadows, lights, or lines? Yes No
3. Do you ever see people or things that are not there? Yes No
4. Has your vision changed recently? Yes No

Comments: _____

_____

_____

ENT:

1. Do you snore? Yes No
2. Do others complain about your snoring? Yes No
3. Do you suffer from nasal congestion? Yes No
4. Do you have facial pain? Yes No
5. Do you have a chronic sore throat? Yes No

Comments: _____

_____

_____

Endocrine/Hormonal:

1. Have you been diagnosed with thyroid disease? Yes No
2. Have you reached menopause? Yes No
3. List any hormone disease: 1._____ 2._____

Comments: _____

_____

Respiratory:

1. Do you have a chronic cough? Yes No
2. Do you cough up sputum in the morning? Yes No
3. How far can you walk before becoming short of breath? _____
4. Are you short of breath basically all of the time? Yes No

(respiratory continued)

5. Do you have chest pain when taking a deep breath? Yes No
6. Do you smoke? Yes No How many packs per day? _____ How many years? _____
7. What is the date of your last chest x-ray? _____ Where? _____

Comments: _____

_____

_____

Cardiovascular:

1. Have you ever had high blood pressure? Yes No
2. Do you ever have chest pain, pressure sensation in chest, or feel you have a tight ban around chest? Yes No
3. Do you ever feel your heart beating rapidly? Yes No
   If yes, does it make you feel dizzy or lightheaded? Yes No
4. Do you become short of breath when you lay flat? Yes No
5. Do you use 2 pillows because of shortness of breath? Yes No
6. Do you ever have swelling in the feet or ankles? Yes No
   If yes, does it go away at night? Yes No
7. Have you ever had a heart attack? Yes No

Comments: _____

_____

_____

GI:

1. Have you lost or gained any weight in the last 6 months? Yes No
   If yes, list the amount gained or lost. Gained: _____ Lost: _____
2. Does acid liquid come up from your stomach during day or night? Yes No
3. Do you suffer from indigestion? Yes No
4. Do you have nausea or vomiting often? Yes No
5. Do fried foods bother you? Yes No
6. Do you take Tums or other medications for indigestion? Yes No
7. Do you choke on foods or liquids? Yes No
8. Do you have diarrhea, constipation, stomach pain, or blood in bowel? Yes No

Comments: _____

_____

_____

GU:

1. Do you have trouble starting urination? Yes No
2. Does dribbling during urination bother you? Yes No
3. How often do you get up to urinate? _____
4. Do you have difficulty maintaining an erection? Yes No
5. Do you have an early morning erection? Yes No
6. Do you have prostate problems? Yes No
7. Do you lose your urine when you cough or sneeze? Yes No
8. Do you have bladder and/or bowel control problems? Yes No

Comments: _____

_____

_____

Musculoskeletal:

1. Do you have chronic joint or muscle pain? Yes No
2. Do joint or muscle pains bother your sleep? Yes No
3. Have you ever had a diagnosis of fibromyalgia? Yes No

Comments: _____

_____

_____

Skin:

1. Do you have a chronic rash or itching? Yes No

Comments: _____

_____

Neurological:

1. Do you have headaches, dizziness, or episodes of temporary blindness? Yes No
2. Do your hands fall asleep at night? Yes No
3. Do you ever have temporary paralysis on one side of the body? Yes No
4. Do you ever have "spells"? Yes No

Comments: _____

_____

_____

Psychiatric: (This information is confidential and will not be released without written consent by the patient.)

1. Please list any current psychiatric diagnosis you have: _____
2. Has anyone in your family ever had a history of depression? Yes No
3. Have you ever hallucinated? Yes No
4. Are you now or have you ever been suicidal? Yes No
5. At times, do you have the feeling of killing someone else? Yes No
6. Are you moody? Yes No
7. Do you become angered easily? Yes No
8. Do you feel mad most of the time? Yes No
9. Do you feel tense or nervous? Yes No
10. Do you feel hopeless? Yes No
11. Do you feel trapped? Yes No

Comments: _____

_____

Social History:

1. What was the highest grade/college attained? _____
2. Present occupation: _____
3. Have you traveled outside the United States in the last year? Yes No
4. Hobbies: _____ _____ _____

Comments: _____

_____

Past Medical History: (Please check if you have had any of the following medical disorders.)

____ Epilepsy/seizures
____ Stroke
____ Neuromuscular disease
____ Headaches/ ____ Migraines
____ Spinal cord injury
____ Cervical spine disease
____ Lumbar spine disease
____ Peripheral nerve disease
____ High cholesterol/ ____Low cholesterol
____ Coronary artery disease
____ Arrhythmias
____ Congestive heart failure
____ Tuberculosis
____ Alcohol abuse
____ Mumps/ ____ Measles
____ Thyroid problems
____ Rheumatic fever
____ High blood pressure/ ____ Low blood pressure
____ Heart Murmur
____ Chronic pulmonary disease
____ Pneumonia
____ Asthma
____ Ulcer
____ Colonic polyps
____ Diabetes
____ Liver disease or hepatitis
____ Kidney disease
____ Venereal disease
____ Arthritis
____ Cancer
____ HIV
____ Drug use
____ Emphysema
____ Polio
____ Allergy/Hay fever
____ Depression

What operations have you had and when?

1. _____ Date: _____
2. _____ Date: _____
3. _____ Date: _____

For what illness have you been hospitalized?

1. _____ Date: _____
2. _____ Date: _____
3. _____ Date: _____

Do you have any blood relatives who have had any of the following? (KEY: F = father, M = mother, FP = father's parents, MP = mother's parents, S = siblings, C = children)

Heart disease:	F	M	FP	MP	S	C	Hypertension:	F	M	FP	MP	S	C
Diabetes:	F	M	FP	MP	S	C	Cancer:	F	M	FP	MP	S	C
Arthritis	F	M	FP	MP	S	C	Kidney disease:	F	M	FP	MP	S	C
Thyroid disease:	F	M	FP	MP	S	C	Epilepsy:	F	M	FP	MP	S	C
Stroke:	F	M	FP	MP	S	C	Mental illness	F	M	FP	MP	S	C
Asthma:	F	M	FP	MP	S	C	Rheumatic heart dis.:	F	M	FP	MP	S	C