Patient Name: _____ Medical Record#_____
Last First M.I.

Age: _____ Date of Birth: _____ Sex: M F (circle)

PHYSICIAN INFORMATION

Primary Care Physician:_____ Specialty:_____

Address: _____

Phone: _____ Fax: _____

Referring Physician:_____ Specialty:_____

Address: _____

Phone: _____ Fax: _____

Name of Person Referring You to the Sleep Center: _____

Would you like your records to go to any other physician? Yes ☐ No ☐

Other Physician:_____ Specialty:_____

Address: _____

Phone: _____ Fax: _____

1. Briefly describe your sleep problem: _____

_____

At what age did this problem begin? _____

How does this affect your life and daily activities? _____

_____

How serious a problem is this for you on a scale of 1 to 10? (1 is not serious and 10 is very serious) _____

2. Have you had any previous evaluations (exam or sleep study)? ☐ Yes ☐ No

When: _____ Where:_____ Results _____

3. Have you had any previous treatment? ☐ Yes ☐ No

When: _____ Where:_____ What type: (i.e., CP AP) _____

4. Please list any medications (prescribed or otherwise) that you have used to help your sleep problem:

DRUG	AMOUNT	FREQUENCY	HOW LONG?	HOW USEFUL?	PHYSICIAN

SLEEP HABITS

5. If employed, what are your usual working hours?

Start: _____ a.m./p.m. Stop:_____ a.m./p.m.

6. Do you ever change work shifts? ☐ Never ☐ Infrequently ☐ Regularly

7. Write in the time you usually go to bed and get up on weekdays.

Go to bed _____ a.m./p.m. Wake Up _____ a.m./p.m.

8. Write in the time you usually go to bed and get up on weekends.

Go to bed _____ a.m./p.m. Wake Up _____ a.m./p.m.

9. Do you have a regular sleep partner? ☐ Yes ☐ No

10. On the average, how long does it take you to fall asleep? _____Minutes

11. What do you ordinarily do just prior to going to sleep? (e.g. reading, TV, bath, etc.)

☐ Reading ☐ TV ☐ Bath ☐ Exercise ☐ Eat

Other: _____

12. On the average, how often do you wake up during the night? _____ Times

13. Do you ever wake up too early in the morning and then are unable to return to sleep? ☐ Yes ☐ No

14. On the average, how long are you actually asleep at night? _____hours _____minutes

15. How do you ordinarily awaken? ☐ Spontaneously ☐ Alarm Clock ☐ Other

16. How difficult is it for you to awaken and get out of bed after sleeping?

☐ Very Difficult ☐ Difficult ☐ Sometimes Difficult ☐ No Problem

17. How long does it take for you to be alert and functioning after sleeping? _____ hours _____ minutes

18. Do you nap or return to bed after arising?

If yes, how many times per day? _____Average length of nap:_____ _____ hours _____ minutes

19. Are you bothered by sleepiness during the day? ☐ Yes ☐ No

20. Do you feel you get too much sleep at night? ☐ Yes ☐ No

21. Do you feel you get too little sleep at night? ☐ Yes ☐ No

22. Do you usually feel tired during the day? ☐ Yes ☐ No

If yes, what do you attribute this to? _____

_____

23. Do you find yourself falling asleep when you don't mean to? ☐ Yes ☐ No

If yes, describe: _____

_____

How long does the sleep episode last? _____ hours _____minutes

Do you feel rested or refreshed after the sleep episode? ☐ Yes ☐ No

24. Have you ever suddenly fallen? ☐ Yes ☐ No

25. Have you ever experienced sudden bodily weakness (jaw, head, shoulders, arms, legs)? ☐ Yes ☐ No

If you have suddenly fallen or experienced weakness, were you aware of things around you? ☐ Yes ☐ No

Was the fall or weakness brought on by any particular event or feeling (laughter, fear, sadness, etc)? ☐ Yes ☐ No

If so briefly describe: _____

_____

26. Have you ever-experienced muscle weakness or paralysis upon:

Going to sleep? ☐ Yes ☐ No

Awakening from sleep? ☐ Yes ☐ No

How often does this occur? _____ Times/Week

27. Have you experienced seeing things or hearing voices that weren't real?

On going to sleep? ☐ Yes ☐ No

During the night? ☐ Yes ☐ No

On awakening from sleep? ☐ Yes ☐ No

During the day? ☐ Yes ☐ No

28. Have you experienced a feeling like falling or the bed moving?

On going to sleep? ☐ Yes ☐ No

During the night? ☐ Yes ☐ No

On awakening from sleep? ☐ Yes ☐ No

During the day? ☐ Yes ☐ No

29. Do you have difficulty breathing at night?

If so briefly describe: _____

_____

_____

How often? _____ Times/Night When did this first occur? _____ (Age)

30. Have you been told you snore when you sleep? ☐ Yes ☐ No

Does the snoring disturb: ☐ Yes ☐ No

A bed partner (or someone in the same bedroom)? ☐ Yes ☐ No

Someone in the next room? ☐ Yes ☐ No

31. Have you been told you stop breathing when you sleep? ☐ Yes ☐ No

32. Have you experienced, upon laying in bed, before sleep, or on awakening from sleep, a restless of legs, "nervous leg," a creeping crawling sensation of legs or twitching? ☐ Yes ☐ No

How often does this occur? _____ times/week

How long does the sensation last? _____ minutes

Does anything relieve the sensation (e.g. getting out of bed, a massage, medication, etc)? _____

_____

When did you first experience this? _____ (age) ☐ Yes ☐ No

33. Has anyone ever told you that your arms or legs jerk or twitch while you are asleep? ☐ Yes ☐ No

If yes, how often during the night does this occur? _____ times/night

How many nights per week does this happen? _____ times/week

At week age did this come to your attention? _____

Does this seem to awaken you from sleep? ☐ Yes ☐ No

34. Have you ever experienced doing something without being aware at the time of this action? ☐ Yes ☐ No

If so briefly describe: _____

_____

_____

How often does this occur? _____ times/week

35. Do you know or do others tell you that:

		Treatment
Talk while apparently asleep?	☐ Yes ☐ No _____ times/week	_____ age started _____
Walk while apparently asleep?	☐ Yes ☐ No _____ times/week	_____ age started _____
Grit teeth while apparently asleep?	☐ Yes ☐ No _____ times/week	_____ age started _____
Wet the bed during sleep?	☐ Yes ☐ No _____ times/week	_____ age started _____
Wake up screaming or seemingly afraid?	☐ Yes ☐ No _____ times/week	_____ age started _____
Have disturbing dreams?	☐ Yes ☐ No _____ times/week	_____ age started _____
Have unusual movements?	☐ Yes ☐ No _____ times/week	_____ age started _____
Awake during the night with headaches?	☐ Yes ☐ No _____ times/week	_____ age started _____
Have erections while asleep (males)?	☐ Yes ☐ No _____ times/week	_____ age started _____

ALLERGIES *(Specify drug and reaction):*

_____ _____

_____ _____

_____ _____

_____ _____

MEDICATIONS

Do you use any prescribed medications either regularly or occasionally? ☐ Yes ☐ No

If so, please list by name below (include over the counter medications, herbal products, supplements, and vitamins)

Name of Medication	Amount	How Often	Reason Used	How Long Used	Prescribing Physician

Give the year of your last physical examination: _____

Results of this exam: _____

Height: _____ inches Weight: _____ pounds Neck size: _____ inches

Have you now or ever in the past experienced any health problems or had surgery associated with the below listed areas?

	Yes	Type of Problem	Dates	Physician, Clinic or Hospital
A - mental health				
B – head or nervous system				
C – eyes, ears, nose, mouth, throat				
D – heart, circulation				
E – breathing (lungs)				
F – stomach, digestive				
G – urine, kidney				
H – sexual				
I – bones, joints, arms, legs				
J – diabetes, glands				
K – blood pressure				
L – weight problems				
M - other				

SOCIAL HISTORY (tobacco, caffeine, alcohol, drug use)

Do you currently smoke cigarettes? ☐ Yes ☐ No How many years? _____ # packs per day _____

Have you used tobacco products like cigars, pipes, or smokeless tobacco? ☐ Yes ☐ No

How many years? _____ # per day _____

Do you currently consume alcohol? ☐ Yes ☐ No

How many years? _____ What type? _____ Amount per day _____

On the average, how many alcoholic beverages do you drink on weekdays? _____

On the average, how many alcoholic beverages do you drink on the weekends? _____

Have you received treatment for substance abuse? ☐ Yes ☐ No

On average, how much do you drink of the following beverages?

Coffee _____ cups/day

Tea _____ cups/day

Carbonated or other soft drinks _____ cups/day

OCCUPATIONAL HISTORY

Current job _____ Year started _____

Previous positions _____

FAMILY HISTORY

Marital Status: _____ Number of Children _____ Ages _____

Family member	Age	Living	Deceased	Illnesses*	Cause of Death	List Sleep Problems
Father						
Mother						
Brothers						
Sisters						
Children (indicate sex)						

**Include cancer, diabetes, heart attacks, high blood pressure, strokes, tuberculosis, and other major illnesses.*

EPWORTH SLEEPINESS SCALE FORM

Instructions: Be as truthful as possible. Print the form. Read the situation in the first column; select your response from the second column; enter that number in the third column. Total all of the entries in the third column and enter the total in the last box.

Situation	Responses	Score
Sitting and Reading	0 = would never doze 1 = slight chance of dozing 2 = moderate chance of dozing 3 = high chance of dozing	
Watching Television	0 = would never doze 1 = slight chance of dozing 2 = moderate chance of dozing 3 = high chance of dozing	
Sitting inactive in a public place, for example, a theater or a meeting	0 = would never doze 1 = slight chance of dozing 2 = moderate chance of dozing 3 = high chance of dozing	
As a passenger in a car for an hour without a break	0 = would never doze 1 = slight chance of dozing 2 = moderate chance of dozing 3 = high chance of dozing	
Lying down to rest in the afternoon	0 = would never doze 1 = slight chance of dozing 2 = moderate chance of dozing 3 = high chance of dozing	
Sitting and talking to someone	0 = would never doze 1 = slight chance of dozing 2 = moderate chance of dozing 3 = high chance of dozing	
Sitting quietly after lunch when you've had no alcohol	0 = would never doze 1 = slight chance of dozing 2 = moderate chance of dozing 3 = high chance of dozing	
In a car while stopped in traffic	0 = would never doze 1 = slight chance of dozing 2 = moderate chance of dozing 3 = high chance of dozing	
TOTAL SCORE		

REVIEW OF SYSTEMS Check all that apply

General	**Yes**	**No**
Weight gain/loss	☐	☐
Difficulty falling asleep	☐	☐
Need to cut down alcohol consumption	☐	☐
Fever	☐	☐
Change in appetite	☐	☐

Skin	**Yes**	**No**
Rash, sore, or excessive bruising	☐	☐
Lump or growth on skin	☐	☐

Eyes	**Yes**	**No**
Wear glasses	☐	☐
Decreased vision	☐	☐
Pain in eyes	☐	☐

Ears, Nose, Throat, Mouth	**Yes**	**No**
Difficulty or changes in hearing	☐	☐
Earaches	☐	☐
Discharge from ears	☐	☐
Buzzing or ringing in ears	☐	☐
Frequent sneezing	☐	☐
Nose stuffiness or running	☐	☐
Recurrent sore throat	☐	☐
Persistent hoarseness	☐	☐
Dental problems	☐	☐
Sinus problems	☐	☐
Lymph glands or nodes	☐	☐
Frequent nose bleeds	☐	☐

Genitourinary	**Yes**	**No**
Painful urination	☐	☐
Frequent urination	☐	☐
Blood in urine	☐	☐
Difficulty emptying bladder	☐	☐

Musculoskeletal	**Yes**	**No**
Painful joints	☐	☐
Sore muscles	☐	☐
Back pain	☐	☐
Pain in calves of legs	☐	☐
Weakness in extremities	☐	☐
Numbness in extremities	☐	☐

Neuropsychiatric	**Yes**	**No**
Anxiety	☐	☐
Depression	☐	☐
Frequent or severe headaches	☐	☐
Dizziness or faintness	☐	☐
More nervous than average person	☐	☐

Cardiovascular	**Yes**	**No**
Chest pain	☐	☐
Shortness of breath	☐	☐
Abnormal swelling in legs/feet	☐	☐
Fatigue or tire easily	☐	☐

Respiratory	**Yes**	**No**
Cough	☐	☐
Blood in sputum	☐	☐
Wheezing	☐	☐

Endocrine	**Yes**	**No**
Excessive thirst or urination	☐	☐
Change in sexual drive/performance	☐	☐
Change in heat or cold tolerance	☐	☐

Gastrointestinal	**Yes**	**No**
Frequent heartburn/indigestion	☐	☐
Nauseas or vomiting	☐	☐
Diarrhea	☐	☐
Constipation	☐	☐
Blood in stools	☐	☐
Ulcers	☐	☐

For Women Only	**Yes**	**No**
Irregular periods	☐	☐
Bleeding between periods	☐	☐
Are you pregnant	☐	☐
Date of last menstrual period	☐	☐
Ever have an abnormal Pap smear	☐	☐
Lump or growth on breast	☐	☐

Allergic/Immunologic	**Yes**	**No**
Hay fever	☐	☐
Hives	☐	☐
Immunodeficiency	☐	☐

Hematologic/Lymphatic	**Yes**	**No**
Anemia	☐	☐
Excessive bleeding or bruising	☐	☐
Blood transfusions	☐	☐

Reviewed by:

_____ M.D. _____Date

_____ M.D. _____Date

HOSPITAL ANXIETY AND DEPRESSION SCALE

This questionnaire is designed to help your doctor know how you feel. Ignore the numbers printed on the left of the questionnaire. Read each item and underline the reply that comes closest to how you have been feeling in the last week. Don't take too long over your replies; your immediate reaction to each item will probably be more accurate than an exhaustively considered response.

A. I feel tense or "wound up"
3 All of the time
2 A lot of the time
1 From time to time
0 Not at all

D. I still enjoy things I used to enjoy
0 Definitely as much
1 Not quite so much
2 Only a little
3 Hardly at all

A. I get a sort of frightened feeling as if something awful is about to happen
3 Very definitely and quite badly
2 Yes, but not too badly
1 A little, but it doesn't worry me
0 Not at all

D. I can laugh and see the funny side of things as much as I always could
1 Yes
2 Not quite so much now
3 Definitely not so much now
4 Not all

A. Worrying thoughts go through my mind
3 A great deal of the time
2 A lot of time
1 From time to time, but not too often
0 Only occasionally

D. I feel cheerful
3 Not at all
2 Not often
1 Sometimes
0 Most of time

A. I can sit at ease and feel relaxed
0 Definitely
1 Usually
2 Not often
3 Not at all

D. I feel as if I am slowed-down
3 Nearly all of the time
2 Very often
1 Sometimes
0 Not at all

A. I get sort of frightened feeling, like "butterflies in the stomach"
0 Not at all
1 Occasionally
2 Quite often
3 Very often

D. I have lost interest in my appearance
3 Definitely
2 I don't take as much are as I should
1 I may not take as much care
0 I take just as much case as ever

A. I feel restless, as though I have to be on the move
3 Very much indeed
2 Quite a lot
1 Not very much
0 Not at all

D. I look forward with enjoyment to things
0 As much as I ever did
1 Rather less than I used to
2 Definitely less than I used to
3 Hardly at all

A. I get sudden feelings of panic
3 Very often indeed
2 Quite often
1 Not very often
0 Not at all

D. I can enjoy a good book, radio or TV program
0 Often
1 Sometimes
2 Not often
3 Very seldom

A total: _____ D total: _____

Name: _____ Date: _____

TWO WEEK SLEEP DIARY

INSTRUCTIONS:

1. Write the date, day of the week, and type of day: Work, School, Day Off, or Vacation.
2. Put the letter "C" in the box when you have coffee, cola or tea. Put "M" when you take any medicine. Put "A" when you drink alcohol. Put "E" when you exercise.
3. Put a line (I) to show when you go to bed. Shade in the box that shows when you think you fell asleep.
4. Shade in all the boxes that show when you are asleep at night or when you take a nap during the day.
5. Leave boxes unshaded to show when you wake up at night and when you are awake during the day.

SAMPLE ENTRY BELOW: On a Monday when I worked, I jogged on my lunch break at 1 PM, had a glass of wine with dinner at 6 PM, fell asleep watching TV from 7 to 8 PM, went to bed at 10:30 PM, fell asleep around Midnight, woke up and couldn't got back to sleep at about 4 AM, went back to sleep from 5 to 7 AM, and had coffee and medicine at 7:00 in the morning.

Today's Date	Day of the week	Type of Day Work, School, Off, Vacation	Noon	1PM	2	3	4	5	6PM	7	8	9	10	11PM	Midnight	1AM	2	3	4	5	6AM	7	8	9	10	11AM
sample	Mon.	Work		E					A				I									C M				

week 1

week 2

Tampa Pulmonary and Sleep Specialists
4620 N. HABANA AVE., SUITE 101. TAMPA, FL 33614
TELEPHONE (813) 875-9362 FAX (813) 876-7055

PATIENT REGISTRATION FORM

IS TODAY'S VISIT RELATED TO ACCIDENT OR INJURY ? (YES OR NO) _____

IF YES, AUTO OR WORK? _____ DATE OF ACCIDENT/INJURY: _____

RACE: _____ ETHNICITY: _____ DOB: _____ SS#: _____

NAME: _____
FIRST MIDDLE LAST SUFFIX

ADDRESS: _____
STREET CITY STATE ZIP CODE

EMAIL: _____

TELEPHONE #: ( ) _____ ( ) _____ ( ) _____
HOME WORK CELL

EMPLOYER: _____ ADDRESS: _____

REFERRING PHYSICIAN: _____
NAME: ADDRESS:

INSURANCE INFORMATION:

PRIMARY INSURANCE COMPANY: _____ GROUP #: _____

CLAIM ADDRESS: _____

TELEPHONE #: ( ) _____ MEMBER ID #: _____

SUBSCRIBER'S NAME: _____ SUBSCRIBER'S SS #: _____

PATIENT'S RELATIONSHIP TO INSURED: _____ SUBSCRIBER'S DATE OF BIRTH: _____

SECONDARY INSURANCE COMPANY: _____ GROUP #: _____

CLAIMS ADDRESS: _____

TELEPHONE #: ( ) _____ MEMBER ID #: _____

SUBSCRIBER'S NAME: _____ SUBSCRIBER'S SS #: _____

PATIENT'S RELATIONSHIP TO INSURED: _____ SUBSCRIBER'S DATE OF BIRTH: _____

RESPONSIBLE PARTY INFORMATION

NAME OF RESPONSIBLE PARTY IF OTHER THAN PATIENT: _____
LAST FIRST M.I.

SS #: _____ DOB: _____

ADDRESS: _____

TELEPHONE #: _____ EMPLOYER: _____

Tampa Pulmonary and Sleep Specialists
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ASSIGNMENT OF BENEFITS FORM

Name of Insured (print): _____

Social Security Number: _____

I request that payment of authorized insurance benefits, including Medicare, if I am a Medicare beneficiary, be made of on my behalf to Tampa Pulmonary and Sleep Specialists, for any medical services provided to me by that organization.

I authorize the release of any medical or other information necessary to determine these benefits or the benefits payable for related equipment or services to the organization, the Health Care Financing Administration, my insurance carrier or other medical entity. A copy of this authorization will be sent to the Health Care Financing Administration, my insurance company or other entity, if requested. The original will be kept on filed by the organization.

I understand that I am financially responsible to the organization for any charges not covered by health care benefits. It is my responsibility to notify the organization of any changes in my health care coverage. In some cases, exact insurance benefits cannot be determined until the insurance company receives the claim. I am responsible for the entire bill or balance of the bill as determined by the organization and/or my health care insurer if the submitted claims or any part of them are denied for payment. I understand that by signing this form I am accepting financial responsibility as explained above for all payment for products received.

By signing this document, I also acknowledge that I have received a copy of the organization's Notice of Privacy Practices. This acknowlegement is required by the Health Insurance Portability and Accountability Act (HIPAA) to ensure that I have been made aware of my privacy rights.

Name of person signing below (print):

_____

Relationship to Insured:

_____

Signature of Insured or Parent/Guardian:

_____

Date:

_____

HIPAA Patient Questionnaire

1. Please list the family members or other person(s), if any, whom we may inform about your general medical condition and your diagnosis (including treatment, payment and health care operations):

   Name: _____ Phone Number: _____

   Name: _____ Phone Number: _____

   Name: _____ Phone Number: _____

   Name: _____ Phone Number: _____

2. Please list the family members or others, if any, whom we may inform about your medical condition **ONLY IN AN EMERGENCY**.

   Name: _____ Phone Number: _____

   Name: _____ Phone Number: _____

   Name: _____ Phone Number: _____

   Name: _____ Phone Number: _____

3. Please print the address of where you would like your billing statements and/or correspondence from our office to be sent *if other than your home*. (Confidential Communications).

   _____

   _____

4. Please indicate if you want all correspondance from our office sent in a sealed envelope marked "**CONFIDENTIAL**": Yes: ☐ No: ☐

5. Please print the telephone number or email address where you want to receive calls about your appointments, lab and x-ray results or other health care information *if other than your home phone number*: ( ) _____ Email Address: _____@_____

6. Can contidential messages (e., appointment reminders) be left on your telephone answering machine or voicemail? Yes: ☐ No: ☐

7. I understand the Privacy Protection Act and have been offered a copy of the Organization's Notice of Privacy Practices updated for the HITECH Omnibus Rule of 2013.

PATIENT NAME: _____ (guardian if under 18 years)

_____ _____

PATIENT/GUARDIAN SIGNATURE DATE

Tampa Pulmonary and Sleep Specialists	4620 N. Habana Ave., Suite 101, Tampa, FL

Tampa Pulmonary and Sleep Specialists
4620 North Habana Avenue, Suite 101
Tampa, Florida 33614

ACKNOWLEDGEMENT OF RECEIPT OF NOTE OF PRIVACY PRACTICES

"You May Refuse To Sign This Acknowlegement"

I,_____, have received a copy of
(Print Name)

this Office's Notice of Privacy Practices.

_____
(Please Print Name)

_____
(Signature)

For Office Use Only:
We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practice but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communication barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

_____

_____

_____