

**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.

- |  |  |
|--|--|
| <input type="checkbox"/> difficulty falling asleep | <input type="checkbox"/> wake up during night    |
| <input type="checkbox"/> wake up too early         | <input type="checkbox"/> excessive daytime sleep |
| <input type="checkbox"/> 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. \_\_\_\_\_

SLEEP HISTORY - CONTINUED

(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 band 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.)

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