Name:

# SLEEP DISORDER CENTER

502 East Pine Ave Crestview, FL 32539
111 Bailey Drive Suite 2 Niceville, FL 32578
151 Mary Esther Blvd. Suite 203 Mary Esther, FL 32569
(850) 689-5496 • (850) 243-4456 • (850) 279-4442 Fax: (850) 689-5497

## SLEEP DISORDER QUESTIONNAIRE

***Please complete this form in its entirety and bring with you to your appointment***

Name_____ Date_____

Address _____

City / State / Zip Code _____

Home Phone _____Work _____Cell _____ Emergency Contact _____

Date of Birth _____Age _____ Height _____ Weight _____ Neck Circumference_____

Social Security _____Marital Status _____ Sex _____ Race _____

Employer _____ Occupation _____

Referring Physician _____ Phone _____

Address of Referring Physician _____

Family Physician (if different from Referring Physician) _____

Address _____ Phone_____ Date last seen _____

Additional Physician(s) you would like the Interpretation sent to: _____

Address: _____

**Medicare**: Are you covered under both Medicare Part A and B? _____Our billing is done through **Medicare Part B only**

Primary Insurance Carrier Name _____ Phone _____

Primary Insurance Carrier Address _____

ID # _____ Group # _____ Sponsor: _____ ID#_____

Secondary Insurance Carrier Name _____ Phone _____

Secondary Insurance Carrier Address _____

ID # _____ Group # _____ Sponsor: _____ ID#_____

1. Have you ever been diagnosed with a sleep disorder? Yes ☐, No ☐ If so, please list where diagnosis was

Name:

made and when. _____

2. Have you ever had a surgical procedure to eliminate snoring or sleep apnea? Yes ☐, No ☐

If so, what type of surgical procedure was done _____

What was the surgical procedure done to correct? _____

Where was the procedure performed? _____ When? _____

Was the surgical procedure effective? _____

3. Are you now or have you ever-used CPAP (Continuous Positive Airway Pressure) Yes ☐, No ☐

If yes, are you still using CPAP? _____ What is your pressure? _____If no, why? _____

_____

4. Have you ever been diagnosed with breathing problems (COPD, Chronic Bronchitis, Asthma, etc)? _____

If so, are you on oxygen therapy? Yes ☐, No ☐ If yes, do you use oxygen all the time or just at night? ___

_____

5. Have you ever been diagnosed with any heart problems or have had a heart attack? Yes ☐, No ☐

If yes, please explain: _____

6. Do you snore? Yes ☐, No ☐ Does position affect your snoring? Yes ☐, No ☐

7. Have you ever been told that you stop breathing (apnea) when you sleep? Yes ☐, No ☐

8. Are you sleepy during the day? Yes ☐, No ☐ Are you tired during the day? Yes ☐, No ☐

9. Please **CHECK** all the statements that apply to you:

☐Night Sweats ☐Morning Headache ☐Morning Confusion ☐Sleep Talk

☐Teeth grinding ☐Loss of Libido (sexual drive) ☐Loose Urine while asleep ☐Sleep Walk

☐Restless Sleep ☐Leg/ Arm movements ☐Depression

10. Do you ever awaken with heartburn? Yes ☐, No ☐ Do you use antacids? Yes ☐, No ☐

11. Do you ever fall asleep at inopportune times such as: when driving? ☐ during a conversation ☐ at work ☐

If yes please describe: _____

12. Do you get sleepy during sedentary activities such as: watching TV ☐, reading ☐, using a computer ☐,

other _____

Name:

13. What is your usual bedtime on weekdays? _____ Weekends? _____

14. What is your usual awakening time on weekdays? _____ Weekends? _____

15. How long does it usually take for you to fall asleep? _____

16. Are you unable to move your body as you are falling asleep or waking up? _____

If yes, please explain: _____

17. The following statements refer to your sleep hygiene, please check as many as apply to you.

Read in bed ☐ Watch TV in bed ☐ Eat in bed ☐ Write letters or checks in bed ☐

Worry in bed ☐ Allow children to sleep with you ☐ Allow pets to sleep with you ☐

18. Are you a Cigarette or Cigar Smoker? Yes ☐, No ☐ Number of cigarettes smoked per day? _____

How many years have you smoked? _____ If you answered no, have you ever smoked? _____

When did you quit? _____

19. Do you consume alcoholic beverages? Yes ☐,No ☐ If yes, how many alcoholic beverages do you consume per:

day_____ or week _____ or month_____ or year_____? (Specify number; do not write occasionally or rarely)

20. Do you consume caffeinated beverages? Yes ☐, No ☐ If yes, how many beverages do you consume per:

day_____ or week _____ or month_____ or year_____? (Specify number; do not write occasionally or rarely)

21. Please list any other medical problems: _____

_____

22. Please list any **NON-Prescription** Medication (Vitamins, herbs, etc) that you take daily.

Please also note how often you take them: _____

_____

23. Please **print** the names of all prescription medication(s) you take. **Technician Check Box(s) when Verified**

_____☐ _____☐ _____☐

_____☐ _____☐ _____☐

_____☐ _____☐ _____☐

(*Use Back if More Space Is Needed)*

24. Do you have any comments that you feel we need to know about you but did not ask?

_____

_____