Total Sleep Management, Inc.
9550 Bonita Beach Rd., Suite 108
Bonita Beach, FL 34135
phone (239) 444-1919
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TOTAL SLEEP MANAGEMENT

Please print and complete this questionnaire.

HOW DID YOU FIRST HEAR ABOUT OUR CENTER?

❑ Signage ❑ Sleep society ❑ Newspaper ❑ Relative/friend
❑ Physician ❑ Radio ❑ Seminar ❑ Journal
❑ Other

Who is the physician ordering the sleep Study? _____

Physician's address: _____

Physician's phone number: _____

DEMOGRAPHIC INFORMATION

Patient's name: _____ Date of Birth: _____
Last First MI

Home Address: _____
Street City State Zip Code

Home Phone: (_____) _____ Work Phone: (_____) _____

Social Security #: _____

Marital Status: ❑ Married ❑ Single ❑ Divorced ❑ Separated ❑ Life Partner

Place of Employment: _____ Occupation: _____

Sex: _____ Age: _____ Height: _____ Weight: _____lbs.

In case of an emergency, please contact: _____
Name Relationship

Phone #: _____

INSURANCE INFORMATION

Policy Holder/Guarantor Information (if different from the patient):

Name: _____ Social Security #: _____

Relationship to patient: _____ Date of Birth: _____

Place of Employment: _____

Primary Insurance: _____ Phone #: _____

Policy/Member #: _____ Group #: _____

Claims Address: _____

Name of Policy Holder: _____ Relationship: _____

Secondary Insurance: _____ Phone #: _____

Policy/Member #: _____ Group #: _____

Claims Address: _____

Name of Policy Holder: _____ Relationship: _____

The purpose of this questionnaire is to help our physicians understand the nature of your complaints and possible sleep disorder. This information will be held in the strictest confidence. In order to assist us in serving you better, please answer each question completely and as accurately as possible.

As the patient, please answer the following questions marking your answers in the Patient Response column. If applicable, have your sleep partner answer the questions according to his/her observation of your sleep patterns.

	Patient Response	**Partner Response**
How long do you feel you've had a problem with your sleep?		
How many nights a week does your sleep problem affect you?		
On the average, how many hours do you sleep each night?		
How many times do you wake up each night?		
On the average, how long are you awake during the night?		
How long does it normally take you to fall asleep?		
Do you experience the inability to keep your legs still?		
Do you have any unusual sleep patterns? Please describe: _____ _____ _____	❑ YES ❑ NO	❑ YES ❑ NO
Are you currently working shift work? If yes, please describe:_____ _____	❑ YES ❑ NO	

Approximately how many ounces of the following beverages/foods do you consume daily?

Coffee _____ Soft drinks w/caffeine _____ Chocolate _____

Alcoholic drinks _____ Decaf. coffee _____ Tea _____

Check any of the following that you feel apply to you.

❑ Nightmares	❑ Palpitations	❑ Feelings of panic
❑ Unable to relax	❑ Bowel disturbance	❑ Fainting
❑ Headaches	❑ Dizziness	❑ Tense feelings
❑ Poor Memory	❑ Depression	❑ Difficulty with decisions
❑ Shyness	❑ Insomnia	❑ Poor home conditions
❑ Suicidal thoughts	❑ Anxiety	❑ Stomach problems

Answer the following questions utilizing the scale below. Please mark the number that best relates to your symptoms.

Evaluation Scale:
1 – No problem, never occurs
2 – Mild problem, rarely occurs
3 – Moderate problem, happens occasionally
4 – Moderately severe problem, occurs frequently
5- Severe problem, occurs frequently

Is your sleep disturbed by any of the following?:

(a)	Sleeping is an unfamiliar bed……..	① ② ③ ④ ⑤
(b)	Asthma……	① ② ③ ④ ⑤
(c)	Coughing……	① ② ③ ④ ⑤
(d)	Difficulty breathing in a flat position……	① ② ③ ④ ⑤
(e)	Awakening due to regurgitation (throat burning, gagging)……	① ② ③ ④ ⑤
(f)	Urgent need to urinate……	① ② ③ ④ ⑤
(g)	Nasal congestion or stuffiness……	① ② ③ ④ ⑤

How much difficulty have you had with the following?:

(a)	Daytime sleepiness; dozing off or struggling to stay awake……..	① ② ③ ④ ⑤
(b)	Fatigue, exhaustion or lethargy during the day……..	① ② ③ ④ ⑤
(c)	Do you snore while you sleep?……..	① ② ③ ④ ⑤
(d)	Actually falling asleep during the day……	① ② ③ ④ ⑤
	Sleep partner's response……	① ② ③ ④ ⑤
(e)	Work/studies compromised because of fatigue or sleepiness……	① ② ③ ④ ⑤
	Sleep partner's response……	① ② ③ ④ ⑤
(f)	Falling asleep while operating a motor vehicle……..	① ② ③ ④ ⑤
	Sleep partner's response……	① ② ③ ④ ⑤
(g)	Accidents as a result of falling asleep while driving……..	① ② ③ ④ ⑤
	Sleep partner's response……	① ② ③ ④ ⑤
(h)	Feeling sleepy/fatigued after an emotional change (anger/stress)……	① ② ③ ④ ⑤
(i)	Feeling of weakness after a surprise or emotional change……..	① ② ③ ④ ⑤
(j)	Daytime hallucinations or dreaming……	① ② ③ ④ ⑤
(k)	Not being able to move when first waking up, despite the feeling of being awake……	① ② ③ ④ ⑤
(l)	Do you hold your breath, stop breathing, or make "gagging" sounds…..	① ② ③ ④ ⑤
	when sleeping? Sleep partner's response……	① ② ③ ④ ⑤
(m)	Do you wake up gasping for air or feel unable to breath when sleeping?..	① ② ③ ④ ⑤

Do you have any other breathing problems during sleep? _____

_____

Have you ever seen a psychiatrist or mental health counselor? ❑ YES ❑ NO

If yes, please explain: _____

_____

_____

Is there any additional information pertaining to your sleep evaluation that you feel is important to explain? Is there anything you feel was not covered by this questionnaire? If so, please explain:

_____

_____

_____

_____

Are you on home oxygen? ❑ YES ❑ NO

- How many hours a day? _____ hours
- How many liters per minute during the day? _____ liters/minute
- How many liters per minute during the night? _____ liters/minute

Medical History
Please list any chronic present or past medical illness diagnosed by a physician (i.e., diabetes, hypertension, incontinence, etc.)

1.
2.
3.
4.
5.

Please list the medications you take on a daily basis. (Prescription and Over the counter)

Medication	Daily Dosage