PULMONARY / SLEEP PATIENT REGISTRATION FORM

Welcome to Tampa Bay Pulmonary Medicine, P.A., Ivan F. Ackerman, M.D., and Jonathan P. Axel, M.D. Please fill out this entire form and attach your driver's license and insurance cards so that the front desk person may copy them. PLEASE PRINT.

PATIENT INFORMATION

Name: _____ SOC #: _____ D.O.B.: _____ Sex: M F

Address: _____ City: _____ State: _____ Zip: _____

Home Phone #: _____ Work: _____ Other: _____

Physical Address: _____

(Needed if you need any Medical Equipment, i.e., Oxygen) Marital Status: M S D Are you a student? Y N

Referring Physician: _____ PCP: _____

Emergency Contact (Not living with you): _____ Phone #: _____

*Required Information: Race ☐ Asian ☐ Hispanic/Latino ☐ White ☐ Other _____ ☐ Black/African American

Ethnicity: ☐ Hispanic/Latino ☐ Non-Hispanic

Language: ☐ English ☐ Spanish ☐ Other _____

INSURANCE INFORMATION

Primary Insurance: _____ Policy #: _____ Group#: _____

Medical Benefits #: _____ Precertification #: _____

Insurance Address: _____

Name of Employer that Insurance is Through _____ Name of Employee: _____

Secondary Insurance: _____ Policy #: _____ Group#: _____

Medical Benefits #: _____ Precertification #: _____

Insurance Address: _____

Name of Employer that Insurance is Through _____ Name of Employee: _____

I consent to treatment necessary for the care of the above named patient. I authorize the release of all medical records to the referring and family physicians and to my insurance company, if applicable. I acknowledge full financial responsibility for services rendered by Tampa Bay Pulmonary Medicine, P.A. I understand that payment of charges incurred is due at the time of service unless other definite financial arrangements have been made prior to treatment. I agree to pay all reasonable attorney fees and collection costs in the event of default of payment of my charges. I further authorize and request that insurance payments be made directly to Tampa Bay Pulmonary Medicine, P.A. should they elect to receive such payment.
I have read and fully understand the above consent for treatment, financial responsibility, release of medical information and insurance authorization.

_____ Signature

_____ Witness

_____ Date

TAMPA BAY PULMONARY MEDICINE, P.A.

IVAN F. ACKERMAN, M.D., F.C.C.P.
JONATHAN P. AXEL M.D.
402 Noland Drive
Brandon, Florida 33511

AUTHORIZATION TO OBTAIN OR RELEASE OF MEDICAL RECORDS FROM MEDICAL PROVIDERS

I hereby authorize Ivan F. Ackerman, M.D., or Dr. Jonathan P. Axel, M.D. to obtain any and all medical records concerning my care from any physician, hospital or other health care profession that has provided medical care in the past. I also authorize the Practice to release any and all medical records concerning my care to any physician, hospital or other health care professional providing care to me at any time. Additionally, I authorize the Practice to release any and all medical records concerning my care to Medicare, Medicaid and any insurance company, third party administrator or managed care company.

Patient Signature _____ **Date** _____

AUTHORIZATION TO OBTAIN OR RELEASE OF MEDICAL INFORMATION TO INDIVIDUAL/FAMILY MEMBERS

In accordance with Federal government privacy rules implemented through the Health Care Portability Act of 1996 (HIPPA), in order for your physician or staff of the practice to discuss your condition with members of your family or other individuals that you designate, we must obtain your authorization prior to doing so. In the event of a critical episode or if you are unable to give your authorization due to the severity of your medical condition, the law stipulates that these rules be waived.

☐ I **do not** authorize the Practice to release any information concerning my medical care to any individual.

☐ I authorize the Practice to release any information concerning my medical care to the following individuals:

Name/Relationship _____ **Name/Relationship** _____

Patient Signature _____ **Date** _____ **Witness** _____ **Date** _____

TAMPA BAY PULMONARY MEDICINE, P.A.

IVAN F. ACKERMAN, M.D., F.C.C.P.
JONATHAN P. AXEL, M.D.

At your first office visit, we ask that you complete this in-depth questionnaire to the best of your ability. Though it is time consuming, it provides an excellent database for the efficient evaluation of your medical problems. If you have any questions regarding its completion, please ask the office staff.

NAME: _____

OCCUPATIONAL HISTORY:
List all jobs you have held in your life, type of work done.
Please start with your first job and end with your current or last job.

1. _____ 2. _____
3. _____ 4. _____
5. _____ 6. _____
7. _____ 8. _____

HAVE YOU EVER BEEN EXPOSED TO THE FOLLOWING SUBSTANCES?
(Circle all that apply)

Acids
Alcohols (industrial)
Alkalis
Ammonia
Arsenic
Asbestos
Benzene
Beryllium
Cadmium
Carbon Tetrachloride
Chlorinated Naphthalenes
Chloroform
Chloroprene
Chromates
Coal Dust
Cold (severe)
Dichlorobenzene
Ethylene Dibromide
Ethylene Dichloride
Fiberglass
Halothane
Heat (severe)
Isocyanates
Ketones
Lead
Manganese
Mercury
Methylene Chloride
Nickel
Noise (loud)
PBB's
PCB's
Perchloroethylene
Pesticides
Phenol
Phosgene
Radiation
Rock Dust
Silica Powder
Solvents
Styrene
Talc
Toluene
Tbl or Mbl
Trichlorethylene
Trinitrotoluene
Vibration
Vinyl Chloride
X-Rays
Welding Fumes

Are you currently employed? _____ Are you currently retired? _____
Why did you retire? (circle): Age Medical Reason Other _____
Which of the following do you have in your home (check all that apply):

☐ Air Conditioner ☐ Air Purifier ☐ Humidifier ☐ Gas Stove
☐ Electric Stove ☐ Fireplace ☐ Central Heating

Education: What was the highest grade you completed? (circle)
Elementary 1 2 3 4 5 6 7 8 High School 1 2 3 4
College 1 2 3 4 Post-Graduate _____ Other _____

SMOKING: Do you smoke? _____ Have you ever? _____

How many total years? _____ How many packs per day? _____

Have you quit? _____ When? _____

ALCOHOLIC BEVERAGES: Do you drink? _____ How many drinks per day? _____

Beer? _____ Wine? _____ Liquor? _____

HOUSEHOLD PETS: Do you have pets at home? _____ Indoor or outdoor? _____

Please list them (dog, cat, bird, etc.) _____ _____

_____ _____

When was the last time you had the following test: (approximate date or year)

TB Skin Test _____ EKG _____ Chest X-ray _____ Breathing Test _____

MEDICATIONS: Please list medications including vitamins, aspirin, birth control pills, Tylenol, etc.

Current:	Medication Name / Strength	Reason Taken	How Often	Physician

Last 6 months:	Medication / Strength	Reason Taken	How Often	Physician

ALLERGIES: Are you allergic to any medications? What reaction do you have?

Medications: _____ Reaction: _____

_____ Reaction: _____

Other allergies (eggs, dust, animals, etc.): _____

_____

Please check appropriate space if you have had any of these illnesses:

CHILDHOOD ILLNESSES:

Rheumatic Fever _____ Mumps _____ Asthma _____

Scarlet Fever _____ Measles_____ Other _____

ADULT ILLNESSES:

Glaucoma	_____	Stroke or Paralysis	_____
High Blood Pressure	_____	Diabetes	_____
Stomach Ulcers	_____	Arthritis	_____
Hepatitis	_____	Gout	_____
Cirrhosis of Liver	_____	Tyroid Disease	_____
Colitis	_____	Anemia	_____
Diverticulitis	_____	Tuberculosis	_____
Gallstones	_____	Hay Fever	_____
Pancreatitis	_____	Pneumonia	_____
Kidney Stones	_____	Pleurisy	_____
Gonorrhea / Syphilis	_____	Bronchitis	_____
Depression	_____	Emphysema	_____
Nervous Breakdown	_____	Heart Disease	_____
Epilepsy	_____	Cancer	_____

HOSPITALIZATIONS AND SURGERIES: Please list all your hospitalizations and surgeries.

Date	Reason	Doctor/Hospital
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

FAMILY HISTORY: Father = Living _____ Age_____ Illnesses _____

Deceased _____ Age_____ Cause of Death _____

Mother = Living _____ Age_____ Illnesses _____

Deceased _____ Age_____ Cause of Death _____

List the name, living, age, and illnesses:

BROTHERS:

_____

_____

_____

_____

SISTERS:

_____

_____

_____

_____

Please check if any of your blood relatives have had any of the following:

Asthma	_____	High Blood Pressure	_____	Epilepsy	_____
Emphysema	_____	Heart Disease	_____	Cancer	_____
Bronchitis	_____	Stroke	_____	Hay Fever	_____
Tuberculosis	_____	Arthritis	_____	Anemia	_____
Diabetes	_____	Gout	_____	Other	_____

IF YOU HAVE ANY OF THESE SYMPTOMS, PLEASE PUT A CHECK BY THEM.
IF YOU ARE UNSURE PLEASE PUT A (?)

COUGH:

Do you usually cough first thing in the morning?_____
Do you usually cough after going to bed at night? _____
Do you cough everyday for at least three months out of the year? _____
How many years have you had this cough? _____
Do you bring up phlegm or sputum with your cough? _____ What color? _____
How much phlegm do you usually bring up in a 24-hour period? _____(tsp,tbsp,cup)
Have you ever coughed up blood? _____ Did you get an x-ray? _____

WHEEZING:

Have you ever noticed whistling or wheezing in you chest? _____
How frequently? (circle one) Daily Weekly Monthly After Colds Only
Is your wheezing more common during any particular season? _____
Which season? _____
Is your wheezing related to any of the following? (circle all that apply)

House Dust	Animals	Plants or Pollens
Dust or Fumes at Work	Exercise	Cigarette Smoke
Dust or Fumes at Home	Other _____	

CHEST PAIN:

Have you ever had significant chest pain? _____
What makes it worse? (circle all that apply)_____

Exercise	Emotional Upsets	Deep Breaths
Cough	Meals	Skipping Meals
Moving Arms		

How many years have you had this chest pain? _____

ASTHMA:

Have you ever had asthma? _____
Have you ever gone to the Emergency Room for your asthma? _____
How often do you have an attack? _____
Do you have polyps in your nose? _____

SINUSES:

Do you frequently have post-nasal drip? _____
Do you frequently have tenderness over you cheekbones? _____
Have you ever had surgery on your sinuses? _____
Have you every had the following? (check all that apply)

_____ Frequently waking at night with an acid or sour taste in your mouth
_____ Waking up with a sore throat in the morning
_____ A burning-chest pain that goes into your throat, especially when you lie down

REVIEW OF SYMPTOMS: NAME:_____

IF YOU HAVE ANY OF THESE SYMPTOMS, PLEASE PUT A CHECK BY THEM.
IF YOU ARE UNSURE PLEASE PUT A (?)

Weight _____ Have you gained or lost over 10 pounds in the last year? _____

SKIN
_____ Chronic skin condition
_____ Lump or Growth
_____ Change in skin color

EYES
_____ Glasses
_____ Change in vision
_____ Pain in eyes
_____ See halo around lights

EAR
_____ Trouble hearing
_____ Earaches
_____ Discharge from ears
_____ Ringing or buzzing in ears

NOSE AND THROAT
_____ Frequent sneezing
_____ Nose continually stuffy or runny
_____ Frequent sore throats
_____ Hoarseness

BREAST
_____ Lump
_____ Discharge
_____ Pain

HEART AND LUNG
_____ Chest pain with no activity
_____ Other chest pain
_____ Shortness of breath
_____ Sleep with more than 1 pillow to help you breathe
_____ Blood in sputum
_____ Wheezing
_____ Unusual heartbeat
_____ Heart attack
_____ Swollen ankles

GENERAL
_____ Loud snoring
_____ Unusual fatigue
_____ Swollen lymph glands
_____ Fever in past month
_____ Night sweats

ENDOCRINE
_____ Frequent urination
_____ Unusual thirst

GENITOURINARY
_____ Painful urination
_____ Frequent urination
_____ Blood in urine
_____ Discharge from vagina or penis
_____ Blood or puss in urine
_____ Difficulty starting urinating

MUSCULOSKELETAL
_____ Painful joints
_____ Sore muscles
_____ Back pain
_____ Unusual weakness

NEUROPSYCHIATRIC
_____ Frequent or severe headaches
_____ Dizziness or fainting
_____ Depressed
_____ Convulsions / epilepsy

LUNGS
Shortness of breath:
_____ at rest
_____ walking uphill or stairs
_____ walking level with others your age
_____ walking level at your own pace
_____ washing or dressing
How far can you walk without stopping?
_____
Do you exercise regularly?
What type? _____
How often? _____

STOMACH AND LIVER
_____ Frequent heartburn / indigestion
_____ Frequent nausea or vomiting
_____ Stomach pain
_____ Constipation
_____ Bleeding ulcers
_____ Hemorrhoids
_____ Blood in bowel movements
_____ Loss of appetite
_____ Vomiting blood
_____ Black bowel movements

Sleep Questionnaire

BRANDON, PLANT CITY, AND NEW TAMPA SLEEP CENTERS

IVAN F. ACKERMAN, M.D., F.C.C.P. Medical Director
Diplomate, American Board of Sleep Medicine, Fellow - American Academy of Sleep
JONATHAN P. AXEL, M.D.

402 Noland Drive • Brandon, Florida 33511 • (813) 655-2500 • (813) 655-2519 FAX
1704 S. Alexander Street • Plant City, Florida 33566 • (813) 655-2500 • (813) 655-2519 FAX
14471 University Cove Place • Tampa, Florida 33613 • (813) 655-2500 • (813) 655-2519 FAX

Today's Date _____ / _____ / _____

Patient's Name _____
First Middle Last

Address _____

City _____ State_____ Zip Code_____

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

Cell Phone (_____) _____ Email_____

Age _____ Date of Birth _____/_____/____ Sex M or F Marital Status: Single Married Divorced

Height _____ Weight _____ Neck Size _____ inches

Occupation _____

Primary Care Physician: _____
Name

_____
Address Phone

Reason for visit _____

_____

_____

SLEEP QUESTIONS

1.	Do you snore?	Yes	No
2.	Have you been told that your snoring disturbs others?	Yes	No
3.	Has anyone ever told you that you stop breathing during your sleep?	Yes	No
4.	Do you ever wake up gasping for air or choking ?	Yes	No
5.	Do you ever wake up with a dry mouth or sore throat?	Yes	No
6.	Do you ever wake up feeling disoriented or confused?	Yes	No
7.	Do you ever wake up with headaches?	Yes	No
8.	Do you use the restroom frequently at night?	Yes	No
9.	Do you experience acid reflux or acid indigestion at night?	Yes	No
10.	Do you usually have difficulty falling asleep?	Yes	No
11.	Are you bothered by poor sleep quality?	Yes	No
12.	Do you usually feel sluggish, sleepy, or fatigued upon awakening?	Yes	No
13.	Do you usually feel fatigued throughout the day?	Yes	No
14.	Do you have difficulty functioning in social or family situations due to fatigue?	Yes	No
15.	Do you have difficulty functioning at work due to fatigue?	Yes	No
16.	Has your sex drive diminished?	Yes	No
17.	Do you feel that you've lost motivation to do things, or that you've lost interest or pleasure in activities that you used to enjoy	Yes	No
18.	Are you bothered by low mood, irritability, or anxiety during the day?	Yes	No
19.	Do you fall asleep in sedentary situations (like watching TV, at the movies, etc.)	Yes	No
20.	Have you ever had a motor vehicle accident due to sleepiness or fatigue?	Yes	No
21.	Have you ever dozed off while sitting at a traffic light?	Yes	No
22.	Have you ever fell asleep while driving?	Yes	No
23.	Do you tend to fall asleep at inappropriate times?	Yes	No

If so, give an example _____

SLEEP SCHEDULE

1.	What is your usual bedtime?	_____ AM/PM
2.	What time to you usually wake up?	_____ AM/PM
3.	On average, how long would you say you are actually asleep each night?	_____ hours
4.	Do you change your bedtime and rise time on the weekends or days that you do not work?	Yes No

5. How long does it usually take you to fall asleep after you get into bed? _____ minutes

6. How many times do you usually awaken during your sleep? _____ times

7. What is the average duration of your awakenings? _____ minutes

8. Do you read, watch TV or engage in other activities while in bed before you fall asleep? Yes No

9. Do you tend to "watch the clock" before or during your sleep? Yes No

10. Do you nap during the day? Yes No
If so, how long do you usually nap? _____

11. Do you wake up too early and find that you can't go back to sleep? Yes No

12. Do you typically fall asleep earlier than desired or awaken earlier than desired? Yes No

13. Do you suffer from jet lag? Yes No

14. If employed, what are your usual work hours? Start: _____AM/PM End: _____ AM/PM

15. Are you a shift worker? (evenings, nights, or rotating shifts) Yes No

SLEEP MOVEMENTS

1. Do you ever experience painful or unusual sensations of your legs while at rest? Yes No

2. Do painful or unusual sensations of your legs interfere with your ability to fall asleep? Yes No

3. Do you ever experience "twitching" or "jerking" of your feet or legs while asleep? Yes No

4. Do you notice that your hands and feet are cold prior to, during, or after sleep? Yes No

NARCOLEPSY

1. Have you ever experienced "sleep attacks" (sudden, irresistible urge to sleep)? Yes No

2. Upon falling asleep or waking up, have you ever had the experience of seeing things? Yes No

3. Upon falling asleep or waking up, have you ever had the experience of being unable to move your arms or legs, even if you try? Yes No

4. Have you ever done things during the day without having awareness of your actions? Yes No

5. Have you ever had a seizure? Yes No

6. Have you ever experienced sudden muscle weakness while awake? (in mild conditions this could be experienced as a weak grip or leg or arm weakness. In severe conditions, one's legs might buckle and the person might fall to the floor.) Yes No

If yes, was this brought on by an intense emotion? Yes No

7. Do you dream right after falling asleep? Yes No

CARDIAC/ DIABETES HISTORY

1. Have you now, or in the past, received treatment for high blood pressure? Yes No
2. Have you been told that you have an irregular heartbeat (cardiac arrhythmia)? Yes No
3. Have you been told that you have atrial fibrillation (Afib)? Yes No

   If yes, are you taking medication for Afib? Yes No
4. Are you a diabetic? Yes No

   If yes, are you taking medication for diabetes? Yes No

FAMILY SLEEP HISTORY

1. Does anyone in your family have a sleep problem? Yes No

   If so, briefly describe and their relationship to you: _____
2. Is there a history of the following in your family?

   Restless Leg Syndrome Breathing related sleep disorder Narcolepsy

PREVIOUS/CURRENT SLEEP TREATMENTS

1. Have you ever had a sleep study? Yes No

   If so, how long ago and where? _____
2. Did you have sleep apnea? Yes No
3. Are you currently using a CPAP/BIPAP machine? Yes No
4. Are you currently receiving CPAP supplies from a DME company? Yes No

   If so, what is the name of the DME company? _____
5. Are you currently using an oral dental device? Yes No
6. Have you ever had surgery to treat sleep apnea? (UPPP surgery) Yes No

   If so, how long ago? _____

FOOD AND BEVERAGES

1. For each item, indicate the average number you drink or eat per day:

   Coffee_____ Sodas _____ Tea _____ Chocolate _____
2. Do you usually drink caffeinated beverages (coffee, tea, soda) within 6 hours of bed? Yes No
3. Do you drink caffeinated beverages during the day to help you stay awake? Yes No
4. Do you drink alcohol (beer, wine, or hard liquor) shortly before bed? Yes No
5. Please circle the number of alcoholic drinks you consume per day:

   1 to 5 5 to 10 10 or more
6. Do you drink alcohol to help you fall asleep? Yes No

SMOKING HISTORY

Do you currently smoke? **Yes No**

If so, how many packs a day? _____ **For how long?** _____

If you have quit smoking, how long has it been since you quit? _____

PARASOMNIAS

Problem Behavior	Check Yes if past or current problem	Frequency/week	Age when symptoms began	If stopped, age when last occured	Ongoing problem?
Sleepwalking	Yes No				Yes No
Sleepwalking associated with "night eating"	Yes No				Yes No
Sleepwalking associated with injury to self/others	Yes No				Yes No
Nightmares	Yes No				Yes No
Night terrors	Yes No				Yes No
Bed wetting	Yes No				Yes No
Sudden unusual movements during sleep	Yes No				Yes No
Sleep talking	Yes No				Yes No
Other (describe)	Yes No				Yes No

MEDICAL HISTORY

Please complete the following checklist by identifying medical conditions that you have now or have had in the past:

System	Type of Problem	Date problem began	Ongoing or date stopped
Head, eyes, ears			
Nose			
Sinuses			
Mouth and throat			
Lungs and chest (COPD)			
Heart (heart attack, high blood pressure)			
Central nervous system (headaches, seizures)			
Digestive system (GERD, etc.)			
Musculoskeletal system			
Endocrine system (overweight, diabetes)			
Skin			
Psychiatric			
Other			

MEDICATION USE

Please list all prescription and over the counter medications that you currently use.

Medication Name	Dose	Number pills taken daily	Check here if medication is used to treat a sleep problem	Effectiveness	Prescribing Doctor

ALLERGIES

Please list all allergies (includes medications, food, and materials)

_____

_____

LIST ANY OTHER HEALTH PROBLEMS YOU HAVE THAT WERE NOT COVERED IN THIS QUESTIONNAIRE BELOW.

_____

_____

_____

_____

EPWORTH SLEEPINESS SCALE

How likely are you to doze off or fall asleep in the following situations?

Use the scale below:

0 – Would never doze
1 – Slight chance of dozing
2 – Moderate chance of dozing
3 – High chance of dozing

Situation	Rank
Sitting and reading	0 1 2 3
Watching TV	0 1 2 3
Sitting inactive in a public place (theater, waiting room, meeting)	0 1 2 3
As a passenger in a car for an hour without a break	0 1 2 3
Lying down to rest in the afternoon when circumstances permit	0 1 2 3
Sitting and talking with someone	0 1 2 3
Sitting quietly after lunch without alcohol	0 1 2 3
In a car while stopped for a few minutes in traffic	0 1 2 3
	Add up total from above: