# 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**

# 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 |
|---|---|---|---|---|---|
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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: |