



Patient Name: _____ Age: _____ Date: _____

Main Problem -

Please describe the main problem you are having regarding your sleep: _____

Sleep Questionnaire –

Duration of Symptoms _____

Factors that make symptoms worse or better _____

Medications taken at bedtime: _____

Bedtime on weeknights: _____ Bedtime on weekends: _____

Wake-up Time weekdays: _____ Wake-up time weekends: _____

How long does it take to fall asleep? _____

Do you wake up at night? Yes No If yes, how many times and why? _____

Do you nap during day? Yes No If yes, for how long? _____

Is your sleep refreshing? Yes No Leg cramps? Yes No Restless legs at night? Yes No

Do you snore? Yes No If yes, how loud? _____

Do you feel sleepy during the day? _____

Has anyone ever witnessed you stopping your breathing? _____

Has your weight changed over the past few years? If so, how? _____

Do you ever suddenly fall asleep or have full body weakness when you hear a funny joke or have extreme emotions?

Do you have morning headaches? Yes No Do you have morning dry mouth? Yes No

Do you gasp or choke during sleep? Yes No Do you have crawling feelings in legs at sleep onset? Yes No

Do you talk in sleep? Yes No Do you sleepwalk? Yes No

Do you fall asleep unexpectedly? Yes No Do you fall asleep while driving? Yes No

Do you have Nightmares? Yes No Do you have leg kicks? Yes No

Unusual behaviors during sleep? Yes No If so, what? _____

SIMEDHEALTH SLEEP CENTER

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Patient Name: _____ Age: _____ Date: _____

Medical History- Please check any disease or condition you have had in the past or have now:

- High blood pressure Diabetes Heart disease Arthritis
- Asthma Glaucoma Heart attack Anemia
- Lung Disease Liver disease Thyroid disease Gout
- Kidney failure Acid reflux/ulcers Fibromyalgia Migraines
- Kidney stones Seizures/Epilepsy Depression Anxiety
- High cholesterol Muscle disease Psychiatric disease Neuropathy
- Cancer (where? _____ When? _____ therapy _____)

Please list any other health problems not described above or describe above condition further: _____

Surgical History-

Please list any surgeries you have had and the approximate dates: _____

Current Medications: Please provide a list of your medications or write them here

Name	Strength (mg)	# of Tablets	# of Times Per Day

What over the counter medications or remedies do you take? _____

List/describe any “alternative” or “complementary” therapies you are receiving: _____

Medication allergies: _____

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Patient Name: _____

Age: _____ Date: _____

Family History –

Relative:	Father	Mother	Sister(s)	Brother(s)	Child(ren)
Age (if living)					
Cause / Age at time of death					
Cancer					
Seizures					
Stroke					
Heart Attack					
Migraines					
Diabetes					
Psychiatric Illness					
High Blood Pressure					
Sleep Apnea					
Narcolepsy					
Restless Leg Syndrome					
Others, Write In					

Social History –

Do you smoke?

- No Did you ever smoke? Yes No If so, how much? _____ How long? _____ When did you quit? _____
- Yes How much per day? _____ For how many years? _____

How much caffeine do you drink/day? _____

What time do you stop drinking caffeine? _____

How much alcohol do you drink? _____

Do you drink alcohol at bedtime? _____

Family- Single Married Divorced Widowed Significant other

Children – How many? _____ What are their ages? _____

Occupation: _____

Education level (how far did you go in school?): _____

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Patient Name: _____ Age: _____ Date: _____

Review of Systems: Please check symptoms you have had in the past 3 months.

Constitutional

- Weight Loss
- Weight Gain
- Recurrent Fevers
- Night Sweats

HEENT

- Severe headaches
- Ringing in the ears
- Change in voice / speech
- Blurred vision
- Difficulty swallowing
- Head injury with loss of consciousness
- Double vision
- Difficulty chewing
- Flashing light in the eyes
- Loss of hearing
- Pain in jaw with chewing
- Brief loss of vision in one eye
- Wake up with dry mouth / headache

Cardiorespiratory

- Chest pain
- Coughing up blood
- Shortness of breath
- Wake from sleep gasping
- Unusual cough
- Palpitations

GI

- Abdominal pain
- Nausea / vomiting
- Chronic diarrhea
- Blood in stool
- Chronic constipation
- Loss of bowel control

GU

- Loss of bladder control
- Sexual difficulties
- Menstrual problems
- Frequent urination at night

Musculoskeletal

- Neck pain
- Back pain
- Joint pain
- Muscle cramping/stiffness

Endocrine

- Tendency to fatigue easily
- Intolerant of heat
- Unusual thirst
- Hair loss
- Urinating often
- Intolerant of cold

Hematologic

- Easy bruising
- Excessive bleeding
- Frequent infections

Neuropsychiatric

- Numbness of arms/legs
- Language problems
- Depressed mood
- Weakness of legs / arms
- Memory loss
- Nervousness/anxiety
- Vertigo / spinning feeling
- Passing out
- Hallucinations
- Tremors / Shaking
- Poor coordination
- Difficulty walking
- Slowness of movements

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