



Comprehensive Neurology and Sleep Medicine, P.A.

Konrad Bakker, MD
Board Certified in Neurology
and Sleep Medicine

Sarah E. Jamieson, PA-C
NCCPA Certified
Physician Assistant

Welcome to Comprehensive Neurology and Sleep Medicine (CNSM). We are glad you have selected the CNSM Team and the Privia Medical Group, as we both are committed to providing quality patient services. Please feel free to reach out to one of our team members if there are any other questions or concerns with your upcoming appointment, as we will be happy to assist you.

Attached you will find our New Patient Packet. We **strongly encourage** all of our new patients to Pre-Register as it can reduce wait time. If you are already a patient under the Privia Medical Group with another provider, we do ask that you still complete our new patient packet. Our New Patient Packet has information that our providers need to help provide you with the best care for your sleep issue(s), not the patient portal registration.

Once you have completed all the paperwork, please send everything, directly to us by any of the following 3 methods. By replying directly to this encrypted email, via our secure fax number, 301-694-0657 or you can even drop it off at our Frederick Office, 5 days a week. By Pre-Registering, this also allows our team to make your status on our waitlist a HIGHER priority as everything is ready to go on our end.

Please make sure to bring the following items with you to your appointment.

- **Original Completed New Patient Packet regardless if emailed, faxed or dropped off**
- **A photo identification card**
- **Current medical insurance(s) card(s) and prescription card(s)**
- **Specialist Copay (if required by insurance) or your Care Coordination Card**
- **Referral (if required by insurance)**
- **Continuous Positive Airway Pressure (CPAP) machine (if you currently use one)**
- **Any Medical Records not previously sent to CNSM related to your sleep issues**

If you choose not to Pre-Register, we do request that you arrive at least 20-30 minutes prior to your appointment time with all the attached information completed and the above list items in hand as well.

Reminder our office requires at least 24 business hours for all reschedules and cancellations. Example, if your appointment is scheduled on a Monday at 9:00am, we need to know that Friday prior to 9:00am, or it would be considered a late cancellation. Sadly, if less than 24 business hours is given, this would incur a \$100.00 rescheduling fee, which must be collected in full at the time of rescheduling a new appointment time.

CNSM has 2 locations, one in Frederick, MD and one in Rockville, MD. The Frederick, MD office is our primary location and both providers work at this location which is at 172 Thomas Johnson Drive, Suite 100. Dr. Konrad Bakker treats patients on Tuesday's and Wednesday's only at the Rockville office, which is at 1901 Research Blvd, Suite 162. Directions and other useful information can be found on our website at MySleepDocs.com

If you have any questions or concerns, please contact the office at 301-694-0900 and a team member will gladly assist you.

Intentionally left blank



Patient Information

Last Name _____

First Name _____

Middle Name _____

Former Last Name _____

Sex _____

DOB _____

SSN _____

Address _____

Address 2 _____

Zip _____

City _____

State _____

Home phone _____

Mobile phone _____

Work phone _____

Email (required) _____

Preferred Pharmacy _____

Contact preference (please circle): HOME MOBILE WORK

Language _____

Race _____

Ethnicity _____

Marital Status _____

Homebound? YES NO

How did you hear about us? (please circle options below)

Advertising Primary Care Physician Specialist Physician Word of Mouth

Insurance Patient in Practice Hospital Insurance Co. Other

Specify (if Other, above) _____

Today's Date _____

Guardian

Last Name _____

First Name _____

Middle name _____

Emergency Contact

Name _____

Relationship _____

Home phone _____

Mobile phone _____

Next of Kin

Name _____

Relationship _____

Phone _____

Employment

Employer name _____

Employer phone _____

Guarantor Information

Last Name _____

First Name _____

Middle name _____

DOB _____

Address _____

Address 2 _____

Zip _____

City _____

State _____

Optional Information

Phone _____

Primary Insurance Information

Insurance Plan Name _____
ID/Certification No. _____
Policy/Group No. _____

Secondary Insurance Information

Insurance Plan Name _____
ID/Certification No. _____
Policy/Group No. _____

Primary Policy Holder (if other than patient)

Patient's Relationship to policy holder: _____
Last Name _____
First Name _____
Middle Name _____
Address _____
Address (ctd) _____
City _____
State _____
Zip _____
Date of Birth _____
Policy Holder Sex _____
Employer Name _____

Secondary Policy Holder (if other than patient)

Patient's Relationship to policy holder: _____
Last Name _____
First Name _____
Middle Name _____
Address _____
Address (ctd) _____
City _____
State _____
Zip _____
Date of Birth _____
Policy Holder Sex _____
Employer Name _____

Patient Signature: _____ **Date:** _____



Authorization and Consent to Treatment

Assignment of Benefits and Authorization to Release Medical Information

I hereby certify that the insurance information I have provided is accurate, complete and current and that I have no other insurance coverage. I assign my right to receive payment of authorized benefits under Medicare, Medicaid, and/or any of my insurance carriers to the provider or supplier of any services furnished to me by that provider or supplier. I authorize Privia to file an appeal on my behalf for any denial of payment and/or adverse benefit determination related to services and care provided. If my health insurance plan does not pay Privia directly, I agree to forward to Privia all health insurance payments which I receive for the services rendered by Privia and its health care providers. I authorize Privia or any holder of medical information about me or the patient named below to release to my health insurance plan such information needed to determine these benefits or the benefits payable for related services. I understand that if my insurance plan does not participate in the Privia network, or if I am a self-pay patient, this assignment of benefits may not apply.

Guarantee of Payment & Pre-Certification

In consideration of the services provided by Privia and its providers, I agree that I am responsible for all charges for services provided not covered by my health insurance plan or for which I am responsible for payment under my health insurance plan. I agree to pay all charges not covered by my health insurance plan or for which I am responsible for payment under my health insurance plan. I further agree that, to the extent permitted by law, I will reimburse Privia for all costs, expenses and attorney's fees incurred by Privia to collect those charges.

If my insurance has a pre-certification or authorization requirement, I understand that it is my responsibility to obtain authorization for services rendered according to the plan's provisions. I understand that my failure to do so may result in reduction or denial of benefit payments and that I will be responsible for all balances due.

Consent to Treatment

As a Privia patient, I voluntarily consent to the rendering of such care and treatment as Privia providers and personnel, in their professional judgment, deem necessary for my health and well-being.

If I request or initiate a telehealth visit (a "virtual visit"), I hereby consent to participate in such telehealth visit and its recording and I understand I may terminate such visit at any time.

My consent shall cover medical examinations and diagnostic testing (including testing for sexually transmitted infections and/or HIV, if separate consent is not required by law), including, but not limited to, minor surgical procedures (including suturing), cast application/removals and vaccine administration. My consent shall also cover the carrying out of the orders of my treating provider by care center staff. I acknowledge that neither my Privia provider nor any care center staff have made any guarantee or promise as to the results that may be obtained.

Consent to Call, Email & Text

I understand and agree that Privia may contact me using automated calls, emails and/or text messaging sent to my landline and/or mobile device. These communications may notify me of preventative care, test results, treatment recommendations, outstanding balances, or any other communications from Privia. I understand that I may opt-out of receiving such communications from Privia and its partners by notifying Privia at privacy@priviahealth.com, by informing my provider's staff or by visiting "My Profile" on my Privia Patient Portal.

HIPAA.

I understand that Privia's Privacy Notice is available at priviahealth.com/hipaa-privacy-notice and my care center's website and that I may request a paper copy at my care center's reception desk.

I hereby acknowledge that I have received Privia's Financial Policy and Privia's Notice of Privacy Practices. I agree to the terms of Privia's Financial Policy, the sharing of my information via HIE, and consent to my treatment by Privia providers. This form and assignment of benefits applies and extends to subsequent visits and appointments with Privia providers.*

Printed Name of Patient: _____

Signature: _____ Date: _____

To be signed by patient's parent or legal guardian if patient is a minor or otherwise not competent.

*Note: If you do not want to participate in Health Information Exchange (HIE), it is your responsibility to follow the instructions outlined on the Privia HIE Opt-Out Request Form and/or contact the HIE directly.



Preferred Communication:

The HIPAA Privacy Rule gives individuals the right to direct how and where their healthcare provider communicates with them. This could, for example, include sending correspondence to your office instead of your home. Please tell us your preferred place and manner of communication. **You may update or change this information at any time; please do so in writing.**

Patient Name: _____ **Date of Birth:** _____

I prefer to be contacted in the following manner (check all that apply):

Send all communication through my Patient Portal.

Home Telephone: _____

OK to leave message with detailed information

Leave message with call-back number only

Cell Phone: _____

OK to leave message with detailed information

Leave message with call-back number only

Work Telephone: _____

OK to leave message with detailed information

Leave message with call-back number only

Written Communication: _____

Please send all of my mail to my home address on file

Please send all mail to THIS address:

Other: _____

Preferred Contacts:

We respect your right to tell us who you want involved in your treatment or to help with your payment issues. You may use this form to name specific individuals who you want us to share your information with; this may include information about your general medical condition and diagnosis (such as treatment and payment options), access to medical records (PHI), prescription pick-up and scheduling appointments. **Please update this information in writing promptly if your preference change.**

Important Note: We may share your information as set forth in our Notice of Privacy Practices to other persons not named on this form as needed for your care or treatment or the payment of services we have provided.

Please indicate the person(s) you prefer we share your information with below:

•Name: _____ Telephone: _____ Relationship: _____

•Name: _____ Telephone: _____ Relationship: _____

•Name: _____ Telephone: _____ Relationship: _____

Patient Signature: _____ **Date:** _____

(To be signed by patient's parent or legal guardian if patient is a minor or otherwise not competent)



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We at Comprehensive Neurology and Sleep Medicine appreciate the opportunity to care for you. Below is a copy of our office policies. Please read and review these policies as they pertain to you.

MEDICATION REFILLS:

We request that you use the patient portal to request your prescription refill(s). If your portal request is received before 3:30pm, your refill be processed within 24 business hours. Otherwise you may leave a message on the refill prescription line [press 4]. Phone prescription refill requests will be processed within 1-3 business days. We generally provide enough medication to last between appointments, but if you run out of a medication before your next scheduled appointment, your medical condition needs to be re-assessed and a follow-up visit is in order.

MISSED APPOINTMENTS:

New patient visits are longer than any other type that we schedule. Due to the length of time reserved exclusively for you to complete the initial evaluation, we ask that you give us as much advanced notice as possible if you need to cancel or change your appointment. There is a minimum requirement of 24 business hours if you are unable to keep the appointment. If you must miss your first appointment without giving the 24 business hours' notice, you will be charged a \$100 no-show fee that must be paid **in full** before a new appointment can be scheduled.

For follow up visits a \$50 fee will apply when 24 business hours' notice is not given, or an appointment is missed. If you come unprepared for your visit, [for example, without a referral or copay if required by my insurance company], or after scheduled appointment time, a \$50 fee could also apply.

Appointments for home sleep studies tests also require a minimum of 24 business hour notice. Canceling or rescheduling without 24 business hours' notice will result in a charge of \$200.

COMPLETION OF FORMS:

We charge \$25 per page to complete forms for such things as FMLA, disability, life insurance, etc. All fees for completion of forms are to be paid in full prior to form completion.

PLEASE SIGN THAT YOU HAVE **READ AND UNDERSTAND THE ABOVE** POLICIES. If the above office policies are not met, I understand that I may be discharged from the practice.

Signature: _____ Date: _____



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PATIENT AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Patient Name Date of Birth

By signing this authorization, I authorize:

Practice/Provider Name Practice/Provider Phone

Practice/Provider Street Address Practice/Provider City, State and Zip

to use and/or disclose certain protected health information (PHI) about me to the party listed below.

Comprehensive Neurology and Sleep Medicine, P.A.

172 Thomas Johnson Drive
Suite 100
Frederick, MD 21702
301-694-0657 Fax

1901 Research Boulevard
Suite 162
Rockville, MD 20850
301-694-0657 Fax

Specifically describe the information to be released, such as date(s) of service, level of detail to be released, origin of information, etc.

I do do not want information relating to psychiatric, drug and/or alcohol abuse and HIV/AIDS diagnoses and treatment included in this release.

- Complete Chart (all documents/notes relating to my care)
Lab/Test Results
Medications/Dosages
Progress Notes
H&P Exam
Consultation Reports

Other:

The information will be used or disclosed for the following purpose:

I am aware that there will possibly be a fee for processing this request. (Initial here)

The purpose(s) is/are provided so that I can make an informed decision whether to allow release of the information. This authorization will expire on (Date of defined event, if no date listed this authorization will expire in six (6) months.)

When my information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice/provider has acted in reliance upon this authorization.

Signature of Patient/Legal Guardian Date

Print Name of Patient/Legal Guardian Date

Please provide the following information

Primary Care Physician _____

City, State _____

Referring Physician _____

City, State _____

Preferred Local Pharmacy _____

City, State _____

Mail order Pharmacy _____

Preferred Lab _____

City, State, Zip _____

Preferred Imaging Facility _____

City, State, Zip _____

All Medications and Supplements currently taking with Dosage and Frequency completed in FULL, please. If it is easier for you to provide a current copy of your current medications already written, please submit to our office, with the New Patient Packet.

Name of Medication: _____

Dosage: _____ Frequency: _____

Additional Instructions: _____

Name of Medication: _____

Dosage: _____ Frequency: _____

Additional Instructions: _____

Name of Medication: _____

Dosage: _____ Frequency: _____

Additional Instructions: _____

CLINICAL HISTORY AND MEDICATION LIST

Name of Medication: _____

Dosage: _____ Frequency: _____

Additional Instructions: _____

Name of Medication: _____

Dosage: _____ Frequency: _____

Additional Instructions: _____

Name of Medication: _____

Dosage: _____ Frequency: _____

Additional Instructions: _____

Name of Medication: _____

Dosage: _____ Frequency: _____

Additional Instructions: _____

Name of Medication: _____

Dosage: _____ Frequency: _____

Additional Instructions: _____

Name of Medication: _____

Dosage: _____ Frequency: _____

Additional Instructions: _____

Name of Medication: _____

Dosage: _____ Frequency: _____

Additional Instructions: _____

Medical History

Name: _____ Date of Birth: _____ Today's Date: _____

Reason For Visit: _____

Allergies: circle and write allergy reaction

| Penicillin | Sulfa | Aspirin | Codeine | Mycins | Tetanus | Other |
|------------|-------|---------|---------|--------|---------|-------|
| | | | | | | |

Family History:

| | Father | Mother | Brother | Sister | Son | Daughter | Other | Other |
|----------------------------------|--------|--------|---------|--------|-----|----------|-------|-------|
| Living/Deceased: L /D | | | | | | | | |
| Artery Disease | | | | | | | | |
| Arrythmia (A-fib) | | | | | | | | |
| Cancer: type | | | | | | | | |
| Diabetes | | | | | | | | |
| Heart Attack | | | | | | | | |
| High Blood Pressue | | | | | | | | |
| Migraine | | | | | | | | |
| Narcolepsy | | | | | | | | |
| Sleep Apnea | | | | | | | | |
| Other: Sleep Issue | | | | | | | | |
| Stroke | | | | | | | | |
| Cause of Death | | | | | | | | |
| Other: explain | | | | | | | | |
| Total number of Siblings: | | | | | | | | |
| Total Number of Children: | | | | | | | | |

Social History:

Tobacco Use: Never Former & Year Quit _____ Current Everyday Current Someday
 Type: Cigarettes Chew Vape/ E-Cigarettes
 How many: _____ packs/single(s) per day/week Years of Use: _____

Alcohol: circle Never Monthly or less 2-4 times a month 2-3 times a week 4 or more a week
 How many: _____ days/week _____ drinks/day

Marital Status: Married: Since _____ Divorced: Since _____ Widowed: Since _____
 Partnered: Since _____ Single

Occupation: circle Full Time Part Time Homemaker Student Unemployed
 Unemployed: Since _____ Disability: Since _____ Retired: Since _____
 Occupation: _____
 Degree (if any): _____

Medical History

Surgical History: *circle/ list all surgeries you have had and year done, note as necessary*

| | | |
|----------------------------|------------------------------------|-----------------------|
| Appendectomy: _____ | Hysterectomy: _____ | Ovaries Remain _____ |
| Tubal Ligation: _____ | | Total _____ |
| Thyroid: type: _____ | Neurosurgery: type _____ | |
| Defibrillator: _____ | Sleep Apnea: _____ | UPPP _____ |
| Vasectomy: _____ | | Inspire _____ |
| Gastro/colon: type: _____ | Bariatric/Weight loss: type: _____ | |
| Maxillofacial: type: _____ | Back/Spine: type: _____ | |
| Cancer: list : _____ | Hernia Repair: type: _____ | |
| Cardiac Other: list: _____ | Cardiac: _____ | Catheterization _____ |
| Orthopedic: list: _____ | | Stent _____ |
| Other: list: _____ | | Bypass _____ |

Past Medical History: *circle/ list all you have been diagnosed with and note as necessary*

| | |
|---------------------------------|----------------------------------|
| Anemia: _____ | Hyperthyroid (high): _____ |
| Arthritis: type: _____ | Hypothyroid (low): _____ |
| Asthma: _____ | Kidney Disease: _____ |
| Atrial Fibrillation: _____ | Insomnia: _____ |
| Blood Transfusion: _____ | Liver Disease: _____ |
| Cancer: Type: _____ | Multiple Sclerosis: _____ |
| Congestive Heart Failure: _____ | Muscular disorder: type: _____ |
| Clotting Disorder: _____ | Obesity: _____ |
| COPD: _____ | Osteoporosis: _____ |
| Heart Disease: _____ | Psychiatric Illness: type: _____ |
| Deep Vein Thrombosis: _____ | Psoriasis: _____ |
| Diabetes: type: _____ | Restless Leg Syndrome: _____ |
| GERD/ Heartburn: _____ | Seizures/ Epilepsy: _____ |
| Heart Attack: _____ | Sleep Apnea: _____ |
| High Blood Pressure: _____ | Stroke: _____ |
| High Cholesterol : _____ | Transient Ischemic Attack: _____ |
| HIV: _____ | |

Other Health History: *list*



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Name: DOB: Today's date:

Please answer all questions as accurately as possible, since your answers will help diagnose and treat your complaints. Please answer the following questions with your sleeping partner as completely and accurately as you can. Bring this questionnaire with you on your first visit. Please ask your sleeping partner to rate your sleep when requested below.

Note: If you have had a recent sleep study and completed this questionnaire at the time of your sleep study, you do not have to complete this questionnaire. Please ask our receptionist to obtain a copy of the one that you previously completed.

GENERAL SLEEP INFORMATION:

- 1. How long have you had a sleep problem?... wks months yrs
Sleep partner's response ... wks months yrs
2. How many nights each week do you have a sleep problem?... nights
Sleep partner's response ... nights
3. What time do you usually go to bed?... am pm
Sleep partner's response ... am pm
4. What time do you usually leave bed to start your morning routine?... am pm
Sleep partner's response ... am pm
5. How many hours do you sleep on an average night?... hours
Sleep partner's response ... hours
6. How many times do you wake up during an average night?... times
Sleep partner's response ... times
7. On average, how long altogether are you awake during the night?... minutes
Sleep partner's response ... minutes
8. Do you take naps? yes no What times? Average length of nap?

AFTER DECIDING TO GO TO SLEEP AT NIGHT:

- 9. Do you have difficulty getting to sleep? yes no
10. How long does it usually take you to fall asleep? minutes
11. Do you experience pain or physical discomfort? yes no
12. Do you feel unable to relax? yes no

Name: _____ DOB: _____

13. Do you have odd sensations or restlessness in your legs as you fall asleep?..... yes no
14. Do you have twitches or movements in your legs or arms as you fall asleep?..... yes no
15. Check which of the following techniques you use to help fall asleep:
() medication () baths, hot tubs, etc () biofeedback
() exercise () hypnosis (tapes, etc) () special diets, foods, drinks or vitamins
() relaxation techniques () mental imagery (counting sheep, etc)

AFTER FALLING ASLEEP:

16. Do you have any unusual sleep behavior? yes no
Sleeping partner's response yes no
If yes, please

describe: _____

17. Do you have problems with nightmares?..... yes no

For questions below that require a simple yes or no answer, circle your choice. For questions with a choice of numbers 1 to 5, please circle the number which best describes your condition using the grading system below:

- 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 very frequently

HOW OFTEN IS YOUR SLEEP DISTURBED DURING THE NIGHT OR AT SLEEP ONSET BECAUSE

OF:

- | | | | | | |
|--|---|---|---|---|---|
| 18. heat? | 1 | 2 | 3 | 4 | 5 |
| 19. cold? | 1 | 2 | 3 | 4 | 5 |
| 20. light? | 1 | 2 | 3 | 4 | 5 |
| 21. any type of noise? | 1 | 2 | 3 | 4 | 5 |
| 22. not being in your usual bed? | 1 | 2 | 3 | 4 | 5 |
| 23. noise or movement of your bed partner? | 1 | 2 | 3 | 4 | 5 |
| 24. some other environment factor? | 1 | 2 | 3 | 4 | 5 |

HOW OFTEN IS YOUR SLEEP DISTURBED BECAUSE OF:

- | | | | | | |
|--|---|---|---|---|---|
| 25. asthma? | 1 | 2 | 3 | 4 | 5 |
| 26. a persistent cough? | 1 | 2 | 3 | 4 | 5 |
| 27. shortness of breath while lying flat? | 1 | 2 | 3 | 4 | 5 |
| 28. "gas" in your stomach, indigestion or heartburn? | 1 | 2 | 3 | 4 | 5 |
| 29. "heartburn", throat burning, choking or gagging? | 1 | 2 | 3 | 4 | 5 |
| 30. awakening due to hunger? | 1 | 2 | 3 | 4 | 5 |
| 31. awakening due to thirst? | 1 | 2 | 3 | 4 | 5 |
| 32. awakening with an urgent desire to urinate? | 1 | 2 | 3 | 4 | 5 |

HOW OFTEN DO YOU:

- | | | | | | |
|---|---|---|---|---|---|
| 33. usually get up to urinate during the night? | 1 | 2 | 3 | 4 | 5 |
| 34. have nasal congestion, stuffiness, or blockage during the night? | 1 | 2 | 3 | 4 | 5 |
| 35. notice your heart pounding or beating irregularly during the night? | 1 | 2 | 3 | 4 | 5 |
| 36. eat excessively during the night? | 1 | 2 | 3 | 4 | 5 |
| 37. snore in any way during sleep? | 1 | 2 | 3 | 4 | 5 |
| Sleeping partner's response..... | 1 | 2 | 3 | 4 | 5 |

Name: _____ DOB: _____

- 38. snore loudly and disruptively? 1 2 3 4 5
 Sleeping partner's response..... 1 2 3 4 5
- 39. hold your breath or stop breathing during sleep? 1 2 3 4 5
 Sleeping partner's response 1 2 3 4 5
- 40. wake up gasping for breath or feeling unable to breathe?..... 1 2 3 4 5
 Sleeping partner: Please describe the breathing problems: _____

DURING THE DAY, HOW MUCH DIFFICULTY HAVE YOU HAD WITH:

- 41. fatigue, tiredness, exhaustion or lethargy? 1 2 3 4 5
- 42. accidents occurring as a result of falling asleep while driving? 1 2 3 4 5
- 43. daytime hallucinations or dreaming? 1 2 3 4 5
- 44. sleep paralysis or not being able to move when first waking up? 1 2 3 4 5
- 45. sudden weakness if surprised, upset or laughing hard?..... 1 2 3 4 5

46. **How likely are you to doze or fall asleep in the following situations, in contrast to feeling just tired?**
This refers to your usual way of life in recent times. Even if you have not done some of these things recently, try to work out how they would have affected you. Use the following scale to choose the *most appropriate number* for each situation:

- 0 = would *never* doze
- 1 = *slight* chance of dozing
- 2 = *moderate* chance of dozing
- 3 = *high* chance of dozing

| Situation | Chance of dozing |
|--|------------------|
| Sitting and reading | _____ |
| Watching TV | _____ |
| Sitting inactive in a public place (e.g. a theater or a meeting) | _____ |
| As a passenger in a car for an hour without a break | _____ |
| Lying down to rest in the afternoon when circumstances permit | _____ |
| Sitting and talking to someone | _____ |
| Sitting quietly after a lunch without alcohol | _____ |
| In a car, while stopped for a few minutes in traffic | _____ |

47. **Check which one of the following statements best describes how sleepy you are during the day?**

- _____ I have no unwanted sleepiness or involuntary sleep episodes.
- _____ Unwanted sleepiness or involuntary sleep episodes occur during activities that require little attention. Examples include sleepiness that is likely to occur while watching television, reading, or traveling as a passenger. Symptoms produce only minor impairment of social or occupational function.
- _____ Unwanted sleepiness or involuntary sleep episodes occur during activities that require some attention. Examples include uncontrolled sleepiness that is like to occur while attending activities such as concerts, meetings or presentations. Symptoms produce moderate impairment of social or occupational function.
- _____ Unwanted sleepiness or involuntary sleep episodes occur during activities that require more active attention. Examples include uncontrolled sleepiness while eating, during conversation, walking, or driving. Symptoms produce a marked impairment of social or occupational function.

GENERAL HEALTH:

- 48. What kind of work do you do? _____
- Do you enjoy it? yes no
- How many weeks of vacation are taken a year? _____ Date of last vacation: _____
- Have you ever worked shift work: yes no If yes, please describe: _____

Name: _____ DOB: _____

49. Do you exercise adequately? yes no How do you exercise? _____

50. On the average, how many of the following do you use each day?
Natural coffee _____ Decaf coffee _____
Tea _____ Chocolate _____
Colas with caffeine _____ Alcoholic beverages _____
Tobacco products _____

51. Check any of the follow that apply to you:
 nightmares headaches stomach problems
 poor appetite depression bad home conditions
 unable to relax dizziness shyness
 difficulty with decisions feel panicky suicide ideas
 palpitations fainting poor concentration
 bowel disturbance feel tense poor memory

52. Do you now see a psychiatrist or a mental health worker? yes no
If yes, please describe: _____

53. Have you ever been treated for alcoholism or drug abuse?..... yes no
If yes please provide details: _____

54. Is there any additional information that you feel may be important pertaining to your sleep study that has not been covered by this questionnaire. If yes, please explain: _____

55. Year of your last physical exam: _____ Physician's name: _____
Address: _____
Phone: _____
Brief results of exam: _____

56. Have you had bariatric surgery? yes no
57. Have you had sleep studies done in the past? yes no
If yes, when and where were the studies done? _____

If you were previously diagnosed with obstructive sleep apnea, please complete this section:

58. In what year was your sleep apnea diagnosed? _____
59. Were you started on CPAP? yes no
If yes, when were you started on CPAP? _____
60. Do you use a CPAP now? yes no
If not, why? _____
61. Have you had surgery for sleep apnea? yes no
62. Have you used a dental appliance for sleep apnea? yes no