CNSM

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. All of our new patients **MUST** complete this New Patient Packet and return it to our office, before we can schedule your appointment. 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 this packet, all 14 pages, not including this cover letter and blank page, please return it to us by any of the following methods. Drop this off at our Frederick Office, 5 days a week, 7:30AM – 4:00PM and then schedule your new patient appointment. Via our secure fax number, 301-694-0657, via USPS mail, or by contacting our office to get an encrypted email sent to you. Once we receive your completed New Patient Packet, a team member will be in touch to schedule your appointment within 48 business hours.

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**

Our office does request that you arrive at least 10-15 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

PRIVIA MEDICAL GROUP

Today's Date

Patient Information

Last Name _____

First Name _____

First Name Used _____

Middle Name _____

Former Last Name _____

Legal Sex _____

Gender Identity
- ☐ Male ☐ Female
- ☐ Transgender FTM
- ☐ Transgender MTF
- ☐ Gender non-conforming
- ☐ Choose not to disclose
- ☐ Other, Please specify:_____

Assigned Sex at Birth
- ☐ Male ☐ Female
- ☐ Choose not to disclose
- ☐ Unknown

Preferred Pronouns
- ☐ he/him ☐ she/her
- ☐ they/them

DOB _____

Address _____

Address 2 _____

City _____

State _____

Zip _____

Home phone _____

Mobile phone _____

Work phone _____

Contact preference HOME MOBILE WORK

May we text you? YES NO

Email (required) _____

Preferred Pharmacy _____

Preferred Lab _____

Preferred Radiology _____

Primary Care Physician _____

Marital Status _____

Homebound YES NO

Language _____

Race _____

Ethnicity _____

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 _____

How did you hear about us?
- ☐ Referred by Friend or Relative:_____
- ☐ Referred by Another Doctor:_____
- ☐ Privia Provider Online Directory
- ☐ Insurance company
- ☐ Advertisement
- ☐ Online Search
- ☐ Other, Please specify:_____

PRIVIA
MEDICAL GROUP

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 _____

Guarantor Information

Last Name _____

First Name _____

Middle name _____

DOB _____

Address _____

Address 2 _____

City _____

State _____

Zip _____

Optional Information

Phone _____

Patient Signature: _____ **Date**: _____

PRIVIA MEDICAL GROUP

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 my provider 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 my provider directly, I agree to forward to my provider all health insurance payments which I receive for the services rendered by my provider and its health care providers. I authorize my provider 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 provider does not participate in my insurance plan's 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 my provider, I agree that I am responsible for all charges for services I receive that are 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 my provider for all costs, expenses and attorney's fees incurred by my provider 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. I voluntarily consent to the rendering of such care and treatment as my providers, in their professional judgment, deem necessary for my health and well-being, however I may refuse any particular treatment or procedure.

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 provider nor any of his or her staff have made any guarantee or promise as to the results that I will obtain.

Consent to Call, Email & Text. I understand and agree that my provider 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 my provider. I understand that I may opt-out of receiving all such communications from my provider by notifying my provider's staff, by visiting "My Profile" on my myPrivia Patient Portal, or by emailing the Privacy Officer at privacy@priviahealth.com.

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

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

Printed Name of Patient: **Email:** _____

Signature: _____ **Date:** _____

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

Name and Relationship of Person Signing, if not Patient: _____

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

PRIVIA MEDICAL GROUP

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:**_____ ☐ **Cell Phone:**_____

☐ OK to leave message with detailed information
☐ Leave message with call-back number only

☐ OK to leave message with detailed information
☐ Leave message with call-back number only

☐ **Work Telephone:**_____ ☐ **Written Communication:**_____

☐ OK to leave message with detailed information
☐ Leave message with call-back number only

☐ Please send all of my mail to my home address on file
☐ Please send all mail to THIS address:
_____
_____

☐ **Other:**_____

My Preferred Contacts:

We respect your right to tell us who you want involved in your treatment or to help you with payment issues. Our secure patient portal is our primary means of patient communication, such as to share your test results. **You** have the ability to control access to your patient portal.

Please indicate the person(s) with whom you prefer we share your information below**Please update this information in writing promptly if your preferences change.**

Please note that in some situations, it may be necessary and appropriate for us to share your information with other individuals. This may include information about your general medical condition and diagnosis (including information about your care and treatment), billing and payment information, prescription information and scheduling appointments.

Note that we generally do not share your information via email, if you wish, you can give another individual access to your secure patient portal. You can set this up yourself through the portal or contact our Patient Experience team at 1-888-774-8428 - Monday – Friday 8 am – 6 pm ET.

•**Name:**_____**Telephone:**_____**Relationship:**_____
Email::_____

•**Name:**_____**Telephone:**_____**Relationship:**_____
Email::_____

•**Name:**_____**Telephone:**_____**Relationship:**_____
Email::_____

ACKNOWLEDGMENT: I understand that HIPAA may permit my provider to share my information with other persons**not** named on this form as needed for my care or treatment or to obtain payment for services provided.

Patient Signature: _____ **Date:** _____
(To be signed by patient's parent or legal guardian if patient is a minor or otherwise not competent)

CNSM

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

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:

As of July 1, 2022, we request that you contact your pharmacy directly for all prescription refill(s) or you must use the patient portal. If your portal request is received before 3:00pm, your refill be processed within 24 business hours, regardless of the alert that appears. You must have a follow up appointment on the books for us to be able to complete a refill request.

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 rescheduling again with our office.

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.

CARD OF FILE:

As of July 1, 2022, we request that patients with a prior collections debt with our office place a card of file for future visits.

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: _____

172 Thomas Johnson Drive Suite 100 Frederick MD 21702 301-694-0900
1901 Research Boulevard Suite 162 Rockville MD 20850 301-694-0901
Fax 301-694-0657 www.MySleepDocs.com

CNSM
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

PATIENT AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Patient Name _____ Date of Birth _____

By signing this authorization, I authorize:

Referring Practice/Provider Name _____ Referring Practice/Provider Phone _____

Referring Practice/Provider Street Address _____ Referring 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 Dates to/from: _____
_____ Medications/Dosages Dates to/from: _____
_____ Progress Notes Dates to/from: _____
_____ H&P Exam Dates to/from: _____
_____ Consultation Reports Dates to/from: _____

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 _____

CLINICAL HISTORY AND MEDICATION LIST

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
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*						

Do you have any siblings? _____ **If yes, how many brothers** _____**, how many sisters**_____
Do you have any children? _____ **If yes, how many sons**_____ **how many daughters**_____

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

Relationship 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: Inspire/Respicardia _____
Vasectomy: _____ Uvulopalatopharyngoplasty (UPPP) _____
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*

_____
_____
_____
_____
_____

CNSM
Comprehensive Neurology and Sleep Medicine, P.A.
Konrad Bakker, MD
Board Certified Neurology
Sleep Medicine
Sarah Jamieson, PA-C
NCCPA Certified
Physician Assistant

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 <u>your</u> 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

172 Thomas Johnson Drive, Suite 100, Frederick, MD 21702 301-694-0900
1901 Research Boulevard, Suite 162, Rockville, MD 20850 301-694-0901
Fax 301-694-0657 www.MySleepDocs.com

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 <u>one</u> 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