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## Comprehensive Neurology and Sleep Medicine, P.A.

**Konrad Bakker, MD**  
Board Certified in Neurology  
and Sleep Medicine

**Sarah Jamieson, PA-C**  
NCCPA Certified  
Physician Assistant

Welcome to Comprehensive Neurology and Sleep Medicine (CNSM). We are glad you have selected CNSM and are committed to providing quality patient services. We look forward to seeing you. This letter outlines the contents of the welcome packet and details about our practice.

We strive to continually offer you individual patient attention and patient/caregiver education and support. To help us provide you the best care possible, we ask that you provide accurate background information and familiarize yourself with our office policies. In this packet you will find:

- **Patient Information Form** – basic contact and insurance information
- **New Patient Medical History Form** – complete medical history to provide us with context for your current condition
- **CNSM Policies** – important office policies to review and sign-off
- **Appointment Checklist** - items to complete for or bring to your first appointment
- **Sleep Questionnaire** (sleep patients only) – list of questions to be completed before your first appointment to help assess and treat your condition
- **Authorization** – place for you to specify which aspects of your care we can discuss with whom

During your initial appointment you will be interviewed and examined by one of our neurologists, Dr. Konrad Bakker or by our experienced physician assistant, Sarah Jamieson, PA-C. The providers at CNSM are experienced in a range of neurological disorders including epilepsy, Parkinson's disease, multiple sclerosis, migraine headaches, neuropathy, carpal tunnel syndrome, Alzheimer's disease, etc. We are also experienced in sleep medicine including sleep apnea, insomnia and restless leg syndrome.

Our highly-respected team looks forward to working with you and making sure that you are fully involved with all aspects of your care. **To help us better serve you, please bring a list of your symptoms and a list of previous medical providers you have seen for this condition. Please also arrange for records from your previous providers to be sent to our office prior to your visit.**

If you have any questions or want to learn more, please see our website ([www.myneurologypractice.com](http://www.myneurologypractice.com)) or contact our office at 301-694-0900.

**Patient Information Sheet**

Date \_\_\_\_\_

Patient's Name \_\_\_\_\_ Patient's SS# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Street Address \_\_\_\_\_

City/State/Zip \_\_\_\_\_ Home Phone (    ) \_\_\_\_\_

E-Mail Address \_\_\_\_\_ Work Phone (    ) \_\_\_\_\_

Gender M\_\_F\_\_ DOB \_\_\_\_\_ Marital Status \_\_\_\_\_ Cell Phone (    ) \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Employer's Address \_\_\_\_\_ City/State/Zip \_\_\_\_\_

Parent/Spouse's Name \_\_\_\_\_ Relationship \_\_\_\_\_

Address \_\_\_\_\_ City/State/Zip \_\_\_\_\_

Spouse's Employer \_\_\_\_\_ Spouse's Work Phone (    ) \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Phone (    ) \_\_\_\_\_

How did you hear about us?    Friend    Family member    Internet    Advertisement    Physician

Referring Physician \_\_\_\_\_ Phone (    ) \_\_\_\_\_

Primary Care Physician \_\_\_\_\_ Phone (    ) \_\_\_\_\_

Address \_\_\_\_\_ City/State/Zip \_\_\_\_\_

Other Doctors You See Regularly \_\_\_\_\_

Name /Address of Your Pharmacy \_\_\_\_\_

\_\_\_\_\_

**INSURANCE INFORMATION**

**PRIMARY Ins Co** \_\_\_\_\_

Address \_\_\_\_\_ City/State/Zip \_\_\_\_\_

Policy/ID # \_\_\_\_\_ Group# \_\_\_\_\_ Subscriber's Name \_\_\_\_\_

Relationship to Subscriber \_\_\_\_\_ Subscriber's DOB \_\_\_\_\_

Subscriber's SS# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

**SECONDARY Ins Co** \_\_\_\_\_

Address \_\_\_\_\_ City/State/Zip \_\_\_\_\_

Policy/ID # \_\_\_\_\_ Group# \_\_\_\_\_ Subscriber's Name \_\_\_\_\_

Relationship to Subscriber \_\_\_\_\_ Subscriber's DOB \_\_\_\_\_

Subscriber's SS# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

**AUTHORIZATION FOR RELEASE OF INFORMATION & AUTHORIZATION TO PAY PROVIDER**

I hereby authorize Comprehensive Neurology & Sleep Medicine to release any information requested from the insurance company with respect to claims and bills as the provider of the services rendered. I hereby authorize payment from the insurance to be sent directly to Comprehensive Neurology and Sleep Medicine for services rendered. I understand that I am financially responsible for the charges that are not covered or considered not medically necessary by the insurance.

Signature \_\_\_\_\_ Date: \_\_\_\_\_

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_  
 Signature \_\_\_\_\_ Today's Date \_\_\_\_\_

REASON FOR TODAY'S VISIT \_\_\_\_\_

**YOUR MEDICAL HISTORY**

	Yes	No		Yes	No
Rheumatic fever, heart disease	_____	_____	Arthritis, Rheumatism	_____	_____
Bone or joint disease	_____	_____	Neuritis, Neuralgia	_____	_____
Bursitis, sciatica, back pain	_____	_____	Polio, Meningitis	_____	_____
Syphilis	_____	_____	Anemia, Jaundice	_____	_____
Tuberculosis	_____	_____	Diabetes	_____	_____
Cancer	_____	_____	High Blood Pressure	_____	_____
Blackouts	_____	_____	Epilepsy, seizures	_____	_____
Migraine headaches	_____	_____	Nervous breakdown	_____	_____
Asthma	_____	_____	Broken bones	_____	_____
Concussion; head injury	_____	_____	Skin rashes	_____	_____
Glaucoma	_____	_____			

**YOUR ALLERGIES**

	Yes	No		Yes	No
Penicillin	_____	_____	Tetanus	_____	_____
Sulfa	_____	_____	Other drugs	_____	_____
Aspirin	_____	_____			
Codeine, Morphine	_____	_____	Foods	_____	_____
Mycins, Other antibiotics	_____	_____	Other (pollen, etc)	_____	_____

If you have an allergy, please list the symptoms you experience. \_\_\_\_\_

**MEDICATIONS:** Please list all of the medications that you currently take. Include the medications that you take on an "as needed" basis.

NAME OF DRUG	DOSE OF PILL	HOW MANY PER DAY
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

**FAMILY HISTORY**

	FATHER	MOTHER	SIBLINGS	CHILDREN
Age	_____	_____	_____	_____
Living/Deceased	_____	_____	_____	_____
Epilepsy	_____	_____	_____	_____
Multiple sclerosis	_____	_____	_____	_____
Migraine headache	_____	_____	_____	_____
Memory loss	_____	_____	_____	_____
Tremor or shaking	_____	_____	_____	_____
Heart problems	_____	_____	_____	_____
Diabetes	_____	_____	_____	_____
Cancer	_____	_____	_____	_____
Cause of death	_____	_____	_____	_____
Other (explain)	_____	_____	_____	_____

**SOCIAL HISTORY**

Are you single/separated/widowed/divorced/married/partnered? If married/partnered, since when? \_\_\_\_\_  
 What is your occupation? \_\_\_\_\_  
 What is your race? \_\_\_\_\_ What is your ethnicity? \_\_\_\_\_  
 What is your preferred language? \_\_\_\_\_

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

How often do you drink alcohol? Never, Rarely, \_\_\_\_\_ per day/week/month  
 Do you use tobacco? Y/N \_\_\_\_\_ pack(s) per day since \_\_\_\_\_ (quit date \_\_\_\_\_)  
 How often do you drink caffeine? Never, Rarely, \_\_\_\_\_ per day  
 Do you use sleeping pills? Y/N Do you use sedatives/tranquilizers? Y/N  
 Do you sleep well? Y/N How many hours per night? \_\_\_\_\_ Do you feel rested? Y/N  
 Have you been treated for alcoholism? Y/N Have you been treated for drug abuse? Y/N  
 Do you exercise? Y/N If so how? \_\_\_\_\_  
 Is your spouse in good health? Y/N If no, describe \_\_\_\_\_

**YOUR SURGICAL HISTORY**

If yes, please provide the approximate date.

	Yes	No	Date		Yes	No	Date
Tonsils	_____	_____	_____	Appendix	_____	_____	_____
Hysterectomy	_____	_____	_____	Gallbladder	_____	_____	_____
Vasectomy	_____	_____	_____	Brain	_____	_____	_____
Disc surgery	_____	_____	_____	Other surgery	_____	_____	_____
Cesarean	_____	_____	_____	Transfusion	_____	_____	_____
Other, nonsurgical hospitalization _____							

**REVIEW OF SYSTEMS: Do you have/feel:**

	Yes	No		Yes	No
Eye disease/injury	_____	_____	Chest pain	_____	_____
Vision loss	_____	_____	Shortness of breath	_____	_____
Ear disease/injury	_____	_____	Palpitations/heart flutter	_____	_____
Fainting spells	_____	_____	Extreme daytime fatigue	_____	_____
Convulsions/seizure	_____	_____	Kidney disease	_____	_____
Paralysis	_____	_____	Trouble urinating	_____	_____
Dizziness	_____	_____	Numbness, part of body	_____	_____
Stomach ulcer	_____	_____	Headaches, frequent/severe	_____	_____
Liver disease	_____	_____	Change in appetite	_____	_____
Tick bites	_____	_____	Dry eyes/mouth	_____	_____
Depression	_____	_____	Anxiety	_____	_____
Memory loss	_____	_____	Difficulty concentrating	_____	_____
Jittery/jumpy	_____	_____	Nasal congestion (chronic)	_____	_____

**YOUR TESTS**

	Yes	No	Date	Result
Chest X-ray	_____	_____	_____	_____
Neck X-ray	_____	_____	_____	_____
Back X-ray	_____	_____	_____	_____
CT Neck/Back	_____	_____	_____	_____
CT Head/Brain	_____	_____	_____	_____
MRI Neck/Back	_____	_____	_____	_____
MRI Head	_____	_____	_____	_____
Myelogram	_____	_____	_____	_____
EKG (heart)	_____	_____	_____	_____
EEG (brain)	_____	_____	_____	_____
EMG/NCV	_____	_____	_____	_____
Sleep study	_____	_____	_____	_____
Other	_____	_____	_____	_____



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NCCPA Certified  
Physician Assistant

### Appointment Checklist

Thank you for entrusting care to us. To provide you with the best service and be responsive to your needs, I suggest you bring the following to your first appointment:

- Completed paperwork from this packet
- Insurance card(s), also any required insurance referrals
- Photo ID
- A list of your previous medical providers, especially if they are neurologists or sleep specialists, and arrange for records from those providers to be sent to our office prior to your appointment.
- Test results such as MRIs, CT scans, lab work, EEGs, sleep studies, etc. that pertain to your current problem.
- A written list of all medications you are currently taking, including strengths and dosages.
- A diary of your symptoms and a list of your questions that you would like to address with the provider.

At all future visits, you will be asked to fill out a patient update sheet before seeing your provider. This sheet assists us in assessing your progress and in determining your treatment plan.

We at Comprehensive Neurology and Sleep Medicine, P.A. appreciate the opportunity to care for you, and we welcome you again to our practice.

Konrad W. Bakker, M.D.  
Medical Director



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### Office Policies

Please review the following and sign at the bottom:

#### **MEDICATION REFILLS:**

We request that you allow 24 hours to process your prescription refill request.

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.

Pain medications for migraines or pain syndromes are prescribed not more than 30 per month to prevent rebound headaches/ addiction/ habituation, etc. If you lose a prescription and/or pill bottle, we will not under any circumstances prescribe more during that 30-day period.

#### **URGENT CARE VISITS:**

If you need to be seen sooner than your next scheduled appointment, for reasons such as a change in your health status, new symptoms, pressing concerns, or forms that need to be filled out quickly, we recommend that you contact us to schedule an urgent care visit. We will make every attempt to accommodate you.

#### **MISSED APPOINTMENTS:**

If you miss an appointment without giving a 24-hour notice, you may be charged a \$25.00 no-show fee. If you miss an appointment more than once without notifying us 24 hours in advance, you may be discharged from the practice.

#### **NOTE TO REFERRING PHYSICIAN:**

At the time of your visit, a letter is dictated and sent to your referring physician and any other physician you would like copied on your behalf. You will also receive a copy of this letter.

#### **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.

We at Comprehensive Neurology and Sleep Medicine appreciate the opportunity to care for you.

#### **PLEASE SIGN THAT YOU HAVE READ THE ABOVE:**

Signature: \_\_\_\_\_ Date: \_\_\_\_\_



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**Authorization**

I, \_\_\_\_\_, give Comprehensive Neurology and Sleep Medicine, P.A. (CNSM) permission to discuss the following:

**(PLEASE CHECK ALL THAT APPLY)**

- \_\_\_\_\_ Diagnosis, prognosis, and/or treatment information
- \_\_\_\_\_ Test results
- \_\_\_\_\_ Scheduling information
- \_\_\_\_\_ Billing and/or insurance information
- \_\_\_\_\_ Other: (please specify) \_\_\_\_\_

With the following people (in addition to my primary care and referring doctors:

- \_\_\_\_\_ Relationship \_\_\_\_\_
- \_\_\_\_\_ Relationship \_\_\_\_\_

My preferred method to be contacted during daytime hours is:

- E-mail, my address is: \_\_\_\_\_
- Daytime phone, my number is: \_\_\_\_\_  
An additional number is: \_\_\_\_\_

I give Comprehensive Neurology and Sleep Medicine permission to leave a message at the above phone number(s) and/or email address.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_



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**NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT**

Effective Date: April 14, 2003

I, \_\_\_\_\_, have been given a copy of the Notice of Privacy Practices and I understand that I can ask questions about how my protected health information (PHI) will be used. I know that I can contact the Secretary of the Department of Health and Human Resources if I have further concerns.

\_\_\_\_\_  
Signature of Patient/Legal Guardian

\_\_\_\_\_  
Date

**MEDICAL & PRESCRIPTION HISTORY CONSENT**

I, \_\_\_\_\_, authorize Konrad Bakker, MD or Sarah Jamieson, PA-C and their associates to review my medical and prescription history as needed for my treatment.

\_\_\_\_\_  
Signature of Patient/Legal Guardian

\_\_\_\_\_  
Date



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### **NOTICE OF PRIVACY PRACTICES**

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THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION CONCERNING YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN OBTAIN ACCESS TO THIS INFORMATION.  
**PLEASE REVIEW CAREFULLY**

This notice describes our organization's practices and those of all employees. When this notice refers to "us" or "we", it is referring to Comprehensive Neurology and Sleep Medicine and each of its entities.

#### **REGARDING YOUR MEDICAL INFORMATION**

We understand that medical information about you and your health is personal, and we are committed to protecting this information. We create a medical record of care and services in order to provide you with quality care and comply with legal requirements. This notice applies to all of the medical records regarding your care that are generated or received by Comprehensive Neurology and Sleep Medicine (CNSM).

This notice will explain ways in which we may disclose medical information about you (your protected health information).

The law requires:

1. Any medical information that identifies you to be kept private and only be used or disclosed as described by this notice or applicable law.
2. That we provide to you this notice pertaining to our legal duties with respect to your medical information and to obtain written acknowledgement from you of its receipt.
3. That we follow the terms of the notice that is currently in effect.

#### **USE AND DISCLOSURE OF MEDICAL INFORMATION**

Below is a list of different ways that we use and disclose medical information and a brief explanation.

- Treatment – we will use and disclose your medical information to provide you with medical treatment or services and to other health providers who are involved in your medical care.
- Payment – we will use and disclose your medical information so that treatment and services you receive can be billed to an insurance company, a government agency such as Medicare and Medicaid or a third party.
- Operations – we may use your medical information to review our treatment and services and to evaluate the performance of our staff in caring for you.
- Treatment alternatives – we may use your medical information to tell you about or recommend possible treatment options that may be of interest to you.
- Reminders – we will use medical information about you to contact you in an effort to provide appointment reminders for medical care.
- Research – under some circumstances we will use and disclose your medical information for research purposes.
- Business Associates – some services are contracted with business associates. To protect your medical information, we require the business associate to appropriately safeguard your information

- We will disclose your medical information if required by federal, state or local law.
- Threat to your health and safety – we will use and disclose your medical information to prevent a serious threat to your health and safety or to the health and safety of another person.
- We may release your medical information to a friend or family member who is involved in your medical care, has power of attorney or similar documentation provided to us. We may also release information to someone who helps pay for your care.
- Special situation – we will release your medical information for workers' compensation or similar programs, public health activities and to notify the appropriate authority if we believe you have been a victim of abuse, neglect or domestic violence.
- We will disclose your medical information if you are involved in a lawsuit or dispute with a valid court or administrative order or in the course of defending ourselves.
- We will disclose your medical information to law enforcement officials when required.
- We will disclose your medical information as necessary to assist coroners and medical examiners.

## WRITTEN AUTHORIZATION

Except as described above, we will disclose your medical information only if you have provided written authorization. This written authorization may be revoked in writing at any time unless we have already taken action on your prior authorization.

You have the right to inspect and obtain a copy of your medical information that is used to make decisions about your care. This is normally limited to medical and billing records. Requests must be made in writing and a fee may be charged for the cost of copying, mailing or miscellaneous supplies.

Your request may be denied in limited circumstances. We may deny your request if we obtained information from another entity that is subject to certain confidentiality agreement and requests from an inmate at a correctional institution. You have the right to have the denial reviewed. The person conducting the review will not be the same person who denied your request. You have the right to ask us to amend your medical information if you feel it is not correct or is incomplete. This right only pertains to the information Comprehensive Neurology and Sleep Medicine has on your medical care. The request must be in writing and you must provide a reason that supports your request. If the request is denied you have the right to submit a written statement disagreeing with the denial. Your statement will be kept on file and attached to all future disclosures with the information to which it relates.

Under the Health Insurance Portability and Accountability Act (HIPAA), you have the right to an accounting of disclosures, which is a list of disclosures of medical information pertaining to you. This accounting will include the date of disclosure, name or organization receiving your medical information along with their address and a brief description of what was disclosed and for what purpose. The request must be submitted in writing. There may be an administrative charge for this accounting to cover the costs of providing the list. You will be notified of the costs involved and may then choose to withdraw or modify your request before any costs are incurred.

There are a few exceptions to this accounting of disclosures:

1. Disclosures made to you.
2. Pursuant to us obtaining your written authorization.
3. For the purpose of carrying out treatment, payment or operations.
4. That is incidental to another permissible use.
5. For national security or intelligence purposes.
6. To correctional institutions or law enforcement officers who have you in custody at the time of disclosure.
7. To a health agency or law enforcement official if requested.

You also have the right to request a limit on your medical information that we disclose about your treatment, payment or healthcare operations or to someone who is involved in your care. We will comply with your request unless the information is needed to provide emergency treatment. The request to limit your medical information must be submitted in writing and must define what information you want to limit, what you are limiting (use, disclosure or both) and to whom the limits apply.

You have the right to request or receive communications on a confidential basis by using alternative means for receipt of information or receiving information at alternative locations. All reasonable requests will be honored.

You have a right to a paper copy of this Notice of Privacy Practices. We reserve the right to make revisions or changes to this notice. We will post the current notice in our waiting room.



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NCCPA Certified
Physician Assistant

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

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 mos yrs
Sleep partner's response ... wks mos 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

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

37. snore in any way during sleep? ..... 1 2 3 4 5  
     Sleeping partner's response..... 1 2 3 4 5
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

<b>Situation</b>	<b>Chance of dozing</b>
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.

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