CNSM

Comprehensive Neurology and Sleep Medicine, P.A.

Konrad Bakker, MD
Board Certified in Neurology
and Sleep Medicine

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172 Thomas Johnson Drive, Suite 100, Frederick, MD 21702 301-694-0900
1901 Research Boulevard, Suite 160, Rockville, MD 20850 301-294-5509
Fax 301-694-0657 www.MyNeurologyPractice.com

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. To pre-register, simply complete all 14 duplex pages attached and request any medical records from previous providers that are related to your sleep issue(s). Once completed, please send the New Patient Packet, directly to us either via our secure fax number, 301-694-0657, our secure email, Jennifer.Kozicki@PriviaMedicalGroup.com, or you can even drop it off at our Frederick Office, 5 days a week. Returning the requested paperwork to our office at least 24 business hours prior to your appointment time, will save our team prep time and then we only need you to arrive 5-10 minutes prior to your scheduled appointment time with the following information in hand.

- **The 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 to not 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.

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).

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 160. Directions and other useful information can be found on our website at MyNeurologyPractice.com

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PRIVIA MEDICAL GROUP

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:** _____

PRIVIA MEDICAL GROUP

Authorization and Consent to Treatment

Assignment of Benefits and Authorization to Release Medical Information
I understand and agree that payment of authorized benefits under Medicare, Medicaid, and/or any of my insurance carriers will be made to me or on my behalf to the provider or supplier of any services furnished to me by that provider or supplier. I authorize any holder of my medical information to release it to Privia, the Health Care Financing Administration (HCFA), the listed insurer and/or agents of the company and/or the listed responsible person(s), and any information necessary to determine my benefits or the benefit for the related services. If my insurance plan does not participate in the Privia network, or if I am a self-pay patient, assignment of benefits may not apply.

Guarantee of Payment & Pre-Certification
In consideration of services provided to me by Privia and its care centers, I agree to be financially responsible and to pay charges for all services ordered by my provider(s). I understand that any balance due as a result of being uninsured or under-insured is payable immediately. I further understand that if I fail to maintain consistent payments, my account will be referred to a collection agent and/or attorney and I agree to pay all collection related charges.

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

Consent to Treatment
As a Privia patient, I voluntarily consent to the rendering of such care and treatment as the 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 understand I may terminate such visit at any time.

My consent shall include medical examination 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 include 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 has made any guarantee or promise as to the results that may be obtained.

Consent to Call
I understand and agree that Privia may contact me using automated calls, emails, and text messaging sent to my landline and 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 voluntarily "opt-in" to receive automated text message communications from Privia and its partners by informing my provider's staff or visiting "My Profile" on my Privia Patient Portal, and agreeing to any additional Terms and Conditions established by my mobile carrier.

I hereby acknowledge that I have received Privia's Financial Policy and 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.

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.

***Note: If patient declines to participate in HIE, patient must follow the appropriate procedure outlined on the Privia HIE Opt-Out Request Form and/or contact the HIE directly.**

CNSM

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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 5]. Phone prescription refill requests will be processed within 3 business days. Some medications require authorization from your insurance company, please allow ample time for us to process these. 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 testing also require a minimum of 24 business hour notice. Canceling or rescheduling without that notice will result in a charge of $200.

If the above office policies are not met, I understand that I may be discharged from the practice.

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:

Signature: _____ Date: _____

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PRIVIA MEDICAL GROUP

Preferred Contacts

The HIPAA Privacy Rule gives individuals the right to direct how and where their healthcare provider communicates with them, such as sending correspondence to the individual's office instead of the individual's home. We invite you to share with 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:**_____
- ☐ **OK to mail to my home address**
- ☐ **OK to mail to my work/office address**

☐ **Other:**_____

Preferred Contacts:
We respect your right to indicate who you prefer that we involve in your treatment or payment decisions and/or who we share your information with, including 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 note, however, that we may share your information as set forth in our Notice of Privacy Practices to other persons as needed for your care or treatment or the payment of services we have provided. Please update this information promptly if your preferences change.

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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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 160
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_____

If it is easier for you to provide a current copy of medications upon checking in, please do so.

All Medications, Supplements and Any Other Medications currently taking:

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: *check all that apply*

	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 and/or children:								

Social History:

Tobacco Use: *circle* Never Former Current Everyday Current Someday
Type: *circle* 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: _____

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 ___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

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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