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 for your healthcare needs, as we both are committed to providing quality patient services.

Attached you will find our New Patient Packet. Our office is accepting new patients, over the age of 18, for sleep issues only. All New Patients are required to complete this New Patient Packet and return it to our office, prior to scheduling an appointment. While our New Patient Packet is lengthy (18 pages/9 pages duplex), it contains important information that our providers need to help provide you with the best care for your sleep issue(s). If you are already a patient under the Privia Medical Group with another provider, you still need to complete this packet in its entirety.

Completed New Patient Packets can be returned to our office during the normal business hours of Monday - Friday between 7:30AM – 4:00PM, which is the preferred method. We will also accept completed New Patient Packets via our secure fax number at 301-694-0657 or via USPS mail, we will not accept emailed copies.

Upon receiving the completed New Patient Packet back in our office, a team member will review the information and then contact you directly to schedule your appointment, with 2 normal business days. If you mailed the completed New Patient Packet back to our office, please allow 7 normal business days to be contacted. If you do not hear from our office within this time frame, please contact us directly at 301-694-0900, Option 3.

Once your appointment has been scheduled, if you would prefer to come in sooner we can add you to our wait list. Our office does request that you arrive at least 10-15 minutes prior to your appointment time to have ample time to check in. Please make sure you have all the following items in hand at your appointment.

- **A photo identification card**
- **Current medical insurance(s) card(s) and prescription card(s)**
- **Specialist Copay (if required by insurance)**
- **Specialist Insurance 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 need to cancel or reschedule your upcoming appointment, please remember our office requires at least 24 business hours for all reschedules and cancellations. For example, if your appointment is scheduled on a Monday at 9:00am, we need to know if you need to cancel or reschedule prior to that Friday at 9:00am, or it would be considered a late cancellation. 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 the new appointment time.

Please feel free to reach out to one of our team members if there are any other questions or concerns with your upcoming appointment and a team member will gladly assist you.

We're looking forward to partnering with you on your journey to a better sleep.

Sincerely,

Konrad Bakker, MD
Sarah E. Jamieson, P.A.

172 Thomas Johnson Drive, Suite 100, Frederick, MD 21702
Phone 301-694-0900 Fax 301-694-0657
www.MySleepDocs.com

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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:_____

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Primary 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 _____

Guarantor Information

Last Name _____

First Name _____

Middle name _____

DOB _____

Address _____

Address 2 _____

City _____

State _____

Zip _____

Optional Information

Phone _____

Secondary Insurance Information

Insurance Plan Name _____

ID/Certification No. _____

Policy/Group No. _____

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:** _____

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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. 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 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; however, I may refuse any treatment or procedure at any time.

Consent for Telehealth Services. If I request or initiate a telehealth visit (a "virtual visit"), I acknowledge that I have reviewed the Informed Consent for Telehealth Services.

My consent shall cover medical examinations, procedures and 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 (such as stitches), cast application/removals, and vaccine administration. My consent shall also cover treatment by care center staff acting under my provider's supervision and direction. 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. My consent shall also cover the use of photography and internal recording devices for the purpose of scribing and clinical documentation improvement. All internal recording adheres strictly to Health Insurance Portability and Accountability Act (HIPAA) compliance guidelines to ensure your data is secured and protected.

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, the Informed Consent for Telehealth Services (if applicable), as well as my provider's Notice of Privacy Practices. I agree to the terms of my provider's Financial Policy and the Informed Consent for Telehealth Services. I also agree to 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 <u>not</u> want to participate in Health Information Exchange (HIE), it is <u>your</u> responsibility to follow the instructions outlined on the my provider HIE Opt-Out Request Form and/or contact the HIE directly.**

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Informed Consent for Telehealth Services

I, the undersigned patient (or personal representative), acknowledge that I have read and fully understand this consent form. I agree to receive healthcare services from the provider listed below via telehealth.

Permitted Activities

I understand and consent to the use of telehealth services for the following activities, as determined to be appropriate by my practitioner:

- Diagnosis, evaluation, and treatment of my condition.
- Prescription refills.
- Appointment scheduling and management.
- Patient education and counseling.
- Consultation with other healthcare providers.
- Remote patient monitoring.

Practitioner's Role and Determination

I understand and agree that it is the role of the practitioner to determine whether or not my condition is appropriate for a telehealth encounter. I acknowledge that my practitioner may, at any time, determine that an in-person visit is necessary and may discontinue telehealth services.

Privacy, Security, and Risks

I understand that the laws protecting the privacy and confidentiality of my medical information apply to telehealth services. I have been informed of the following security measures to protect my information, as well as the potential risks to my privacy:

- **Security Measures:** All patient information transmitted during or in relation to telemedicine services is protected through transport-level encryption, such as Transport Layer Security (TLS) for email and HTTPS for web-based communications. Data on all workstations is encrypted at rest using whole disk encryption to render it unusable and unreadable to unauthorized individuals. These technical safeguards are part of a comprehensive security program designed to protect electronic Protected Health Information (ePHI) including the use of unique user IDs for system access, requiring multi-factor authentication, and conducting regular security risk assessments.
- **Potential Risks:** I acknowledge that despite these security measures, there are potential risks to my privacy, including but not limited to, the possibility of technical failures, data breaches, or unauthorized access during the telehealth session.

Hold Harmless Clause

I agree to hold my provider and their staff harmless for any information lost due to technical failures, including but not limited to, interruptions in video or audio connections, internet outages, or hardware malfunctions.

Third-Party Information Sharing

I understand that my patient-identifiable information will not be forwarded to a third party for any reason without my express, written consent, unless permitted under applicable law.

Patient Rights

I understand that I have the right to withhold or withdraw my consent to the use of telehealth services at any time, without affecting my right to future care or treatment. I also understand that I have the right to access my medical information and copies of my medical records.

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.

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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. You have the ability to control access to your patient portal. You can set this up yourself through the portal, or contact our Patient Experience team at 1-888-774-8428, Monday - Friday, 6am - 11pm ET.

There may be times when it is necessary for us to communicate with you about your healthcare or payment issues outside of the portal. If there are any individuals who are involved in your healthcare treatment, or payment for your healthcare services, please indicate below 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.

•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)

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

Patient Authorization to Release Protected Health Information

Patient Name _____ **Date of Birth** _____

Referring Practice/Provider Name _____ **Referring Practice/Provider Phone Number** _____

Referring Practice/Provider Street Address _____ **Referring Practice/Provider City, State and Zip** _____

By signing this authorization, I authorize the physician/physician group listed above to disclose certain protected health information (PHI) about me to **Comprehensive Neurology and Sleep Medicine, P.A., 172 Thomas Johnson Drive, Suite 100, Frederick, MD 21702 at Fax 301-694-0657**

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

_____ Complete Chart **(all documents/notes relating to my SLEEP issue(s) only)**
_____ Consultation Reports and Progress Notes – **sleep issues only** Dates to/from: _____
_____ Lab/Test Results/**All Sleep Studies** Dates to/from: _____
_____ Progress Notes – **sleep issues only** 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

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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.

OFFICE POLICIES:
Our normal office hours are Monday-Friday, 7:30am-4:00pm EST, excluding the holidays which can be found on our website at www.MySleepDocs.com, Our office requests "24 normal business hours" for all items (refills, cpap concerns, voicemail messages, ect) to be addressed. An example is a refill request comes in on a Friday at 3pm, please allow us until Monday at 3pm to address this item. We do our best to address all items as quickly as possible, even when we are short staffed, so please be understanding of this.

PATIENT PORTAL:
We value your privacy. Due to federal HIPAA laws, we require that all patient-physician communications containing personal health information be conducted through our secure, encrypted patient portal, not standard email.

MEDICATION REFILLS:
We request that you contact your pharmacy directly for all prescription refill(s) or you must use the patient portal. 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. Please remember our office requires at least 24 business hours for all reschedules and cancellations. For example, if your appointment is scheduled on a Monday at 9:00am, we need to know if you need to cancel or reschedule prior to that Friday at 9:00am, or it would be considered a late cancellation. 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 the new appointment time.

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 your insurance company], or after your 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.

Multiple missed appointments could lead to a possible discharge from the practice.

Signature: _____ Date: _____

CONTINUE ON NEXT PAGE FOR MORE OF OUR OFFICE POLICIES

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Comprehensive Neurology and Sleep Medicine, P.A.

VIRTUAL VISITS:
For our office to perform a Virtual Visit, the patient needs to be in a state that borders Maryland (PA, DE, VA, WV, DC) during that visit with your provider. If not, the appointment will be terminated and a possible $50 late cancellation fee might be applied. Virtual Visits mean that you are using the Privia App for Audio and Video or Iphone's FaceTime only. Our office can not accept Phone Call Appointments going forward. The patient agrees to pay the Specialist copay at the time of checking in for their appointment. If your specialist copay amount is missed or not paid in full at multiple check in times, all future visits might be scheduled in person.

INSURANCE SPECIALIST REFERRAL:
If your insurance company requires a Specialist Referral for your visits, this must be a valid referral, which is approved by our office staff prior to your upcoming appointment. Obtaining and keeping track of how many visits are left on a valid insurance referral is the patient's responsibility, not our office, however, we do assist as much as we can. If a valid referral is not received within 48 business hours prior to your upcoming appointment time, there are two options.

1. You can choose to sign an Insurance Referral Waiver and make the Self-Prompt Pay payment rate prior to your appointment time.
2. Reschedule your upcoming appointment 24 business hours ahead of the scheduled appointment to avoid late cancel fees.

CREDIT CARD ON FILE:
We request that patients with a prior collections debt with our office place a card of file for future visits.

COLLECTIONS:
If your account has been sent to Collections, there is a possibility that you could 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.

FINANCIAL POLICY, NOTICE OF PRIVACY PRACTICES & HIPAA PRIVACY NOTICE:
The Financial Policy, Notice of Privacy Practices and HIPAA Privacy Notice can be found online at www.MySleepDocs.com at any time.

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. If you would like a copy of this for your records, please notify a team member.

Signature: _____ Date: _____

172 Thomas Johnson Drive, Suite 100, Frederick, MD 21702
Phone 301-694-0900 Fax 301-694-0657
www.MySleepDocs.com

MEDICATION LIST

Please list all Medications and Supplements that you are currently taking with Dosage and Frequency. If you already have a current list of your Medications and Supplements, please feel free to add that list to the New Patient Packet when returning it to our office.

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: _____

[OVER]

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	Other	Other	Other	Other	Other

Family History:

	Father	Mother	Brother	Brother	Sister	Sister	Son	Son	Daughter	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*

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Patient Name:_____ DOB:_____

Please answer all the questions as accurately as possible, as your answers will help us diagnose and treat your complaints. There are questions for your sleeping partner as well, since they witness your sleep.

****

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
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 environmental factor? 1 2 3 4 5

Patient Name:_____ DOB:_____

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
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	_____

Patient Name:_____ DOB:_____

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 likely 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: _____
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? _____
    Do you have copies of the results? ..... yes no If yes, please provide a copy to our office.

Patient Name:_____ DOB:_____

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 so, where did you get it, who is your Durable Medical Equipment Provider?_____
    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

If you have any other health information that you would like your provider to know about, please use the blank space below.