



# VENTURA ADVANCED SURGICAL ASSOCIATES

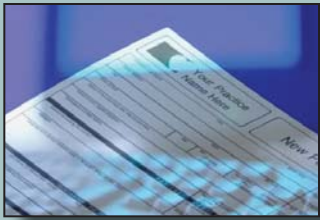
Thank you for considering Ventura Advanced Surgical Associates as your healthcare provider. As part of our commitment to our patients we strive to provide the highest standards in the evaluation and treatment of our patients. In order for us to meet those standards it is imperative that we obtain a detailed medical history from each of our patients. Attached to this letter is our medical history and evaluation form that you will need to complete in order for us to completely understand your medical history. You will only need to complete this form once.

Please take the time to address and answer each question as they are all important in completing your evaluation. The entire document will be reviewed with you at your initial consultation and will continue to provide important information for our physicians and nurses throughout your evaluation.

Our patient history form includes a comprehensive sleep questionnaire. Obesity increases the risk of sleep apnea which may cause or exacerbate diabetes and hypertension. Sleep apnea may also increase the risk of postoperative complications. If we determine that you have sleep apnea, we will initially treat the condition prior to any surgery to decrease your risk of postoperative complications. With weight loss most patients with sleep apnea improve or are cured, however some patients with sleep apnea are not overweight and it is therefore an important set of questions to consider in all our patients. Please take the time to answer the simple yes and no questions asked in our sleep evaluation.

Once we have a complete medical history and sleep questionnaire we can proceed with your initial evaluation.

Thank you from the staff of Ventura Advanced Surgical Associates.



# NEW PATIENT INFORMATION

PATIENT NAME \_\_\_\_\_ DATE: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_ SEX: \_\_\_\_\_ SOCIAL SECURITY NUMBER: \_\_\_\_\_

MAILING ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP CODE: \_\_\_\_\_

HOME PHONE: \_\_\_\_\_ WORK PHONE: \_\_\_\_\_

CELL PHONE: \_\_\_\_\_ DRIVERS LICENSE NUMBER \_\_\_\_\_

EMAIL ADDRESS \_\_\_\_\_ EMERGENCY CONTACT \_\_\_\_\_

REFERRING PHYSICIAN NAME AND PHONE NUMBER: \_\_\_\_\_

EMPLOYER: \_\_\_\_\_

EMPLOYERS ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP CODE: \_\_\_\_\_

SPOUSES NAME: \_\_\_\_\_

SPOUSES EMPLOYER: \_\_\_\_\_

EMPLOYERS ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP CODE: \_\_\_\_\_

WORK PHONE: \_\_\_\_\_ OCCUPATION: \_\_\_\_\_

## INSURANCE INFORMATION:

INSURANCE CARD HOLDER \_\_\_\_\_

SOCIAL SECURITY NUMBER OF CARDHOLDER \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_

EMPLOYER \_\_\_\_\_

EMPLOYERS ADDRESS \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP CODE \_\_\_\_\_

PRIVATE INSURANCE: \_\_\_\_\_ MEDICARE NUMBER \_\_\_\_\_

1. COMPANY \_\_\_\_\_ GROUP NUMBER \_\_\_\_\_

ADDRESS: \_\_\_\_\_ SUBSCRIBER NUMBER \_\_\_\_\_

PLEASE PROVIDE A COPY OF YOUR DRIVERS LICENSE

2. COMPANY \_\_\_\_\_

ADDRESS: \_\_\_\_\_ PLEASE PROVIDE COPIES OF YOUR INSURANCE CARD

WORK RELATED INJURY? Yes \_\_\_\_\_ No \_\_\_\_\_ DATE OF INJURY \_\_\_\_\_

I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled including Medicare, private insurance, and other health plans to Helmuth T. Billy, MD. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure payment.



# BILLING POLICY STATEMENT

Dear Valued Patient:

It is the policy of our office to collect any deductible, co-payment and/or co-insurance amounts prior to any elective surgery. When you make the final decision to schedule the surgery, the billing department will call you and notify you of the amount you will need to prepay.

Since insurance quotes are sometimes inaccurate, you may owe additional money or be entitled to a refund from our office after the insurance company processes and pays your bill. In any case, we will send you a bill or refund promptly. Please clarify any information regarding this policy prior to your surgery so as to avoid confusion later.

PATIENT  
NAME: \_\_\_\_\_

SIGNATURE: \_\_\_\_\_

DATE \_\_\_\_\_



Helmuth T. Billy, M.D.

Ventura Advanced Surgical Associates

Ventura Advanced Surgical Associates

# OUR FINANCIAL POLICY

Dear Patient,

Thank you for choosing us as your health care provider. The following is our financial policy. Our main concern is that you receive the proper and optimal treatment needed to restore your health. If you have any questions or concerns about our payment policies, please do not hesitate to ask our office staff.

We ask that all patients complete our patient information forms prior to seeing the doctor, as well as reading and signing our financial policy.

Payments for services done in our office are due at the time they are rendered. We bill your insurance company for you. If you do not have any insurance we will bill you directly.

You must understand that:

1. Your insurance policy is a contract between you, your employer and the insurance company. This office is NOT a party to that contract. Our relationship is with you and not your insurance company.
2. All charges are your responsibility whether your insurance company pays or not. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover.
3. If the insurance company does not pay in full within sixty days, we require you to pay the balance due with cash, check or credit card.
4. Returned checks and balances older than 45 days may be subject to additional collection fees and interest charges of 2 1/2 percent per month.

We understand that temporary financial problems may affect timely payment of your balance. We encourage you to communicate any such problems so that we can assist you in the management of your account.

Again thank you for choosing us as your health care provider. We appreciate your trust in us and we appreciate the opportunity to serve you.

Patient/Responsible  
Party \_\_\_\_\_

Date \_\_\_\_\_



# PATIENT INFORMATION MEDICAL HISTORY QUESTIONNAIRE

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

**REASON FOR VISIT:**

- |  |     |    |
|--|-----|----|
| Are you here for evaluation of possible weight loss surgery? | YES | NO |
| Does your weight problem cause:                              |     |    |
| Fatigue?   | YES | NO |
| Diabetes?  | YES | NO |
| High blood pressure  | YES | NO |
| Arthritis  | YES | NO |
| Snoring  | YES | NO |

Describe any other problems or reasons for visit:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**MEDICATIONS:**

NAME OF DRUG	DOSAGE	DOSES PER DAY
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

**ALLERGIES**

Are you allergic to any medications? YES NO  
If yes, please list which medications and the reactions:

_____	reaction: _____
_____	reaction: _____
_____	reaction: _____
_____	reaction: _____
_____	reaction: _____

Patient Name: \_\_\_\_\_

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

I have had the following medical problems:

Problem	Estimated Year of Diagnosis	Management / Special Care / Comments
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

I have had the following SURGICAL procedures:

Procedure:	Year:	Comments:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

I have been involved in the following accidents:

Accident:	Year:	Injuries:
_____	_____	_____
_____	_____	_____
_____	_____	_____

List hospitalizations (other than for elective surgeries):

Date	Reason
_____	_____
_____	_____
_____	_____
_____	_____

Patient Name: \_\_\_\_\_

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

**SOCIAL HISTORY**

Single?	YES	NO	
Married?	YES	NO	How many years? _____
Widowed?	YES	NO	
Divorced?	YES	NO	

Occupation: \_\_\_\_\_

**HABITS:**

**Tobacco**

Do you smoke?	YES	NO	cigarettes/day _____	Years _____
Did you smoke?	YES	NO	cigarettes/day _____	Years _____
When did you quit?	_____			

**Alcohol**

Do you drink alcohol?	YES	NO	Drinks per day? _____
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**Caffeine**

Do you drink coffee, tea, soft drinks?	YES	NO	Cups of coffee per day? _____
			Sodas per day? _____

**OTHER SUBSTANCES**

Do you use or have you ever used any recreational drugs?  
(This information will be maintained strictly confidential)

YES NO

Please list or explain \_\_\_\_\_

**FAMILY HISTORY:**

<b>FATHER</b> AGE _____	<b>MOTHER</b> AGE _____
LIVING _____ DEAD _____	LIVING _____ DEAD _____
CAUSE OF DEATH _____	CAUSE OF DEATH _____
_____	_____
ANY MEDICAL PROBLEMS? _____	ANY MEDICAL PROBLEMS? _____
_____	_____

NUMBER OF CHILDREN \_\_\_\_\_ AGES \_\_\_\_\_

Living \_\_\_\_\_ Deceased \_\_\_\_\_ Cause: \_\_\_\_\_

Any Health Problems in Your Children? YES NO

\_\_\_\_\_  
\_\_\_\_\_

Patient Name: \_\_\_\_\_

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

**Siblings?**

	Living	Deceased	Ages	Cause of Death	Medical Problems
<b>Brothers</b>	_____	_____	_____	_____	_____
	_____	_____	_____	_____	_____
	_____	_____	_____	_____	_____
<b>Sisters</b>	_____	_____	_____	_____	_____
	_____	_____	_____	_____	_____
	_____	_____	_____	_____	_____

**Have any family members ever had?**

Cardiac Disease/Heart Attacks	Yes	No	Anesthetic complications	Yes	No
Lung Disease	Yes	No	Other Disease	Yes	No
Cancer (location)	Yes	No	Thyroid disorders	Yes	No
Diabetes	Yes	No	Stroke	Yes	No
High blood pressure	Yes	No	Bleeding Disorders	Yes	No

If so State Whom and at what Age.

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**Review of Systems:**

Please circle **yes** or **no** to each following diseases, symptoms, or conditions.

**General:**

- Yes**  **No** Problems with anesthesia
- Yes**  **No** Significant weight loss, not associated with dieting. How much in past year \_\_\_\_\_
- Yes**  **No** Significant weight gain. How much in past year \_\_\_\_\_
- Yes**  **No** Night sweats
- Yes**  **No** Fever
- Yes**  **No** Chills

**Dermatologic (Skin):**

- Yes**  **No** Skin rash (includes yeast infections of skin folds)
- Yes**  **No** Skin lesions
- Yes**  **No** Psoriasis, eczema



Patient Name: \_\_\_\_\_

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

**Endocrine:**

- Yes  No Thyroid problems (overactive or underactive)
- Yes  No Diabetes.  Insulin dependent
- Yes  No Hormone replacement therapy

**Head, Eyes, Nose, Throat (HEENT):**

- Yes  No Eye: Blurred vision, double vision, "blackouts"
- Yes  No Ear problems: poor hearing, ringing/buzzing in ears, infections, drainage
- Yes  No Sinus problems: stuffy nose, runny nose, hayfever
- Yes  No Cancer or other diseases of the oral cavity
- Yes  No Change in voice, hoarseness

**Cardiovascular:**

- Yes  No Chest pain ("angina") / Heart attack
- Yes  No High Blood Pressure
- Yes  No Murmur
- Yes  No Pacemaker
- Yes  No Palpitations
- Yes  No History of abnormal EKG or heart study
- Yes  No Congestive heart failure (CHF)
- Yes  No Foot or Ankle Swelling
- Yes  No Disease of peripheral blood vessels (arteries or veins--phlebitis) of the arms, legs or brain

**Respiratory:**

- Yes  No Difficulty Breathing / Shortness of Breath
- Yes  No Snoring
- Yes  No Observed pauses in breathing during sleep
- Yes  No Pneumonia
- Yes  No Bronchitis
- Yes  No Emphysema
- Yes  No Cough
- Yes  No Wheezing
- Yes  No Blood clots in legs or lungs
- Yes  No Lung cancer
- Yes  No Asthma
- Yes  No Coughing up blood
- Yes  No Feeling of smothering when you lie down or are awakened from sleep
- Yes  No Other pulmonary disease \_\_\_\_\_

**Gastrointestinal (GI):**

- Yes  No Heartburn
- Yes  No Stomach Ulcer Disease
- Yes  No Nausea / Vomiting
- Yes  No Vomiting, Spitting, or Coughing up blood
- Yes  No Diarrhea, constipation, blood in bowel movements
- Yes  No Inflammation of the Pancreas
- Yes  No Hepatitis or Liver Problems / Jaundice (Yellow skin or eyes)
- Yes  No Spleen Disease, "Easy bleeding"
- Yes  No Abdominal Problems: stomach pain,
- Yes  No Disease of the Small or Large Intestine
- Yes  No Colon Polyps or Cancer
- Yes  No Intestinal Bleeding / Blood in Stool / Hemorrhoids

Patient Name: \_\_\_\_\_

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

**Genitourinary (GU):**

- Yes  No Do you get up at night to urinate? How many times \_\_\_\_\_
- Yes  No Kidney infections or stones
- Yes  No Renal insufficiency or failure (Dialysis)
- Yes  No Urinary Infection
- Yes  No Incontinence
- Yes  No Frequency
- Yes  No Difficulty / Pain with urination
- Yes  No Prostate problems
- Yes  No Change in libido
- Yes  No Erectile dysfunction

**Gynecologic (Gyn):**

- Yes  No Breast disease, cancer, lumps, pain, discharge (leakage)
- Yes  No Uterine, Ovarian, Menstrual, Pregnancy problems

**Musculoskeletal:**

- Yes  No Back pain / Pain or numbness which extends down to buttocks and/or legs
- Yes  No Joint pain and/or swelling (hip, knee, ankle, hands, neck or other)

**Neurologic:**

- Yes  No Brain disease or head injury
- Yes  No Seizure disorder
- Yes  No Dizziness, lightheadedness, or fainting spells
- Yes  No Headaches
- Yes  No History of stroke
- Yes  No History of Parkinson's Disease
- Yes  No Peripheral neuropathy
- Yes  No Memory problems
- Yes  No Change or decrease in thinking ability, attention
- Yes  No Other neurologic symptoms or problems \_\_\_\_\_

**Psychiatric/Mood:**

- Yes  No Mood change or difficulties:
- Yes  No Depression, suicidal thoughts or actions
- Yes  No Anxiety
- Yes  No Bipolar disorder
- Yes  No Other psychiatric problems or diagnoses \_\_\_\_\_

**Hematologic/Lymphatic/Oncologic (blood, cancer):**

- Yes  No Anemia
- Yes  No Enlarged Lymph Nodes (Glands)
- Yes  No Excessive or prolonged bleeding from cuts or dental procedures
- Yes  No Cancer (not previously listed) \_\_\_\_\_

**My Primary Physician is.**

**I see the following specialists**

Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 Phone: \_\_\_\_\_

Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 Phone: \_\_\_\_\_

**I see the following specialists**

**I see the following specialists**

Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 Phone: \_\_\_\_\_

Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 Phone: \_\_\_\_\_

Patient Name: \_\_\_\_\_

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

**Bariatric History:** Please Circle Yes or No as appropriate

Are your parents overweight? Yes No **Mother** Yes No **Father** Yes No

Are your siblings overweight? Yes No **Sisters** Yes No **Brothers** Yes No

Which relatives are morbidly obese? \_\_\_\_\_

My obesity started:  in childhood  in puberty  as an adult  after pregnancy  
 after a traumatic event  other \_\_\_\_\_

Were you overweight as a teenager? Yes No If so by how many pounds? \_\_\_\_\_

Did you employ any weight loss methods? No \_\_\_\_\_ Yes \_\_\_\_\_

If so what types: \_\_\_\_\_

My weight as an adult has ranged between \_\_\_\_\_ pounds and \_\_\_\_\_ pounds

My most stable weight as an adult has been \_\_\_\_\_ pounds at age \_\_\_\_\_

I maintained this weight for \_\_\_\_\_ years, \_\_\_\_\_ months.

My current weight is \_\_\_\_\_ pounds.

My realistic goal weight is \_\_\_\_\_ pounds.

I felt best at a weight of \_\_\_\_\_ pounds when I was \_\_\_\_\_ years of age

**Eating Patterns:** please check all that apply

**Portions:**  Large  Medium  Small

**Type:**  "Normal"  "Healthy"  "Fast food"  "Junk food"

**Taste Preference:**  
 Sweets  Salty  Comfort Foods  Other \_\_\_\_\_

**Number of meals per day:** \_\_\_\_\_ **Number of snacks per day:** \_\_\_\_\_

**I eat extra calories due to:**

- Stress  Boredom  Sweets Craving  Snacking  "Closet Eating"  Binging

**I have participated in the following Weight Loss Programs/Diets/Medications:**

- Conventional ("self") dieting (limiting calorie intake)  
 Medifast  Meridia  Redux  Phen-fen  Schick Center  
 Nutra-System  Weight Watchers  Jenny Craig  Slim Fast  Diet Center  
 Metabolife  Optifast  Atkins Diet  Lindora  Diet Pills  
 Cambridge  Sansum Wellness  Xenical  Jaw Wiring  Hypnosis  
 Acupuncture  Protein Diet  Medically Supervised Weight Loss Clinics  
 Overeater's Anonymous  
 Other \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Patient Name: \_\_\_\_\_

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

**Doing You Have Any of the Following Weight Related Medical Problems?**

**A. Diabetes:** No \_\_\_ Yes \_\_\_ When Diagnosed \_\_\_\_\_

What kind of diabetes? \_\_\_\_\_

How do you control your diabetes? Diet? \_\_\_ Oral Medications? \_\_\_ Insulin? \_\_\_  
Nothing. \_\_\_

How often do you check blood sugars? \_\_\_\_\_ Average blood sugar \_\_\_(am)\_\_\_(pm)

Complications? \_\_\_\_\_

**B. Blood Lipids:** Have you ever been told that you *cholesterol* or *triglycerides* were too high?

High cholesterol? No \_\_\_ Yes \_\_\_ How high? \_\_\_\_\_ What is it now? \_\_\_\_\_

High Triglycerides? No \_\_\_ Yes \_\_\_ How High? \_\_\_\_\_ What is it now? \_\_\_\_\_

How are/were these conditions treated? Diet? \_\_\_ Oral Medications? \_\_\_ Not treated? \_\_\_

**C. High Blood Pressure:** YES NO When Diagnosed \_\_\_\_\_

How do you control your high blood pressure? Diet? \_\_\_ Oral Medications? \_\_\_ Exercise \_\_\_  
Nothing \_\_\_

What is the highest blood pressure that you can recall? \_\_\_\_\_ Most recent blood pressure \_\_\_\_\_

Complications? \_\_\_\_\_

**D. Gallbladder?** Has your gallbladder been removed? YES NO Date \_\_\_\_\_

Do you have gallstones now? \_\_\_\_\_

Have you had an ultrasound of the gallbladder? YES NO Results? \_\_\_\_\_

Do you get gas, bloating, nausea, or cramps  
after eating fried or fatty foods? \_\_\_\_\_ How often? \_\_\_\_\_

Do you awaken with cramps or abdominal pain at night? \_\_\_\_\_ How often? \_\_\_\_\_

Who in your family has had gallstones? Please list. \_\_\_\_\_

**E. Heartburn:** YES NO When does it occur? \_\_\_\_\_

How often does it occur? \_\_\_\_\_ How many years? \_\_\_\_\_

Is it mainly with certain foods? YES NO

If yes, list those foods. \_\_\_\_\_

Does it awaken you at night? \_\_\_\_\_ How often? \_\_\_\_\_

Do you have pain? \_\_\_\_\_ How often? \_\_\_\_\_

Do you ever awaken coughing and choking with regurgitations? \_\_\_ How often? \_\_\_\_\_

Do you ever regurgitate solid food? \_\_\_\_\_ What time of day does that occur? \_\_\_\_\_

How do you treat these problems?

Restricted diet. \_\_\_ Oral Medications \_\_\_ List any medication. \_\_\_\_\_

Complications? (asthma, pneumonia, laryngitis) Please list: \_\_\_\_\_

Have you ever had an upper GI study or endoscopy? YES NO When \_\_\_\_\_ Results? \_\_\_\_\_

Patient Name: \_\_\_\_\_

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

**WEIGHT LOSS HISTORY - THIS FORM WILL GO TO YOUR INSURANCE COMPANY**

**PLEASE, BE AS COMPLETE AS POSSIBLE**

Date	Weight Loss Episode / Attempt	Beginning Weight	Amount of Weight Lost	Over How Many Months	Weight gained Back?	Over How Long?
Please list in Chronologic order	What kind? Supervised? By whom? Medicine?					

We know you can't remember every diet you've ever been on. Diet history is very important to gaining insurance approval and/or qualifying for surgery. Please do the best you can. Please continue on the back if necessary.

Patient Name: \_\_\_\_\_

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

**GENERAL:**

Do you have problems with sleep?	Yes	No
Are you a light sleeper and easily awakened?	Yes	No
Are you tired and/or sleepy during the day?	Yes	No
Have you had an accident or near accident because of sleepiness?	Yes	No
Does sleepiness affect your work or personal relationships?	Yes	No

***If you answered Yes to any of the above, please answer the following, if not go to page 'SLEEP SCHEDULE:***

Fatigue or malaise	Yes	No
Attention, concentration or memory problems	Yes	No
Social or vocational or school problems	Yes	No
Mood disturbance or irritability	Yes	No
Daytime sleepiness	Yes	No
Motivation or energy reduction	Yes	No
Proneness for errors or accidents at work	Yes	No
Tension, headaches, gastrointestinal symptoms	Yes	No
Concerns or worries about sleep	Yes	No

**SLEEP SCHEDULE:**

Do you do shift work or work a night shift?	Yes	No
---	-----	----

Workdays:

What time do you like to go to bed?	_____
What time do you usually wake up?	_____
For how long do you usually sleep?	_____
Alarm clock?	Yes No

Weekends or non-work days:

What time do you like to go to bed?	_____
What time do you usually wake up?	_____
For how long do you usually sleep?	_____
Alarm clock?	Yes No

Do you ever "sleep in" late?	Yes	No
------------------------------	-----	----

Do you have trouble falling asleep?	Yes	No
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Do you wake up during the night?	Yes	No
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How many times?	_____
For how long?	_____

**SLEEP RELATED BREATHING DISORDERS (SLEEP APNEA):**

Do you snore?	Yes	No	Not sure
Do you stop breathing while asleep (observed by you or by bed partner)?	Yes	No	Not sure
Do you have or are treated for high blood pressure?	Yes	No	Not sure
Do you have heartburn or are treated for reflux?	Yes	No	Not sure
Are you overweight?	Yes	No	Not sure
Have you had atrial fibrillation?	Yes	No	
Do you wake up gasping or choking?	Yes	No	
Have you lost your bed partner because of snoring?	Yes	No	
Do you have morning headaches?	Yes	No	
Do you wake up with a dry mouth?	Yes	No	
Have you been told your limbs kick or twitch?	Yes	No	

Patient Name: \_\_\_\_\_

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

**INSOMNIA**

Do you have problems getting to sleep?	Yes	No	
How long does it take?			_____
How many nights per week?			_____
Do you have problems staying asleep?	Yes	No	
How long does it take to go back to sleep?			_____
How many nights per week?			_____
Do you wake up too early and have difficulty getting back to sleep?	Yes	No	
Do you feel refreshed or restored by sleep?	Yes	No	
Are you depressed or anxious?	Yes	No	
Are you or have you been treated for depression or anxiety?	Yes	No	
Do you sleep better in an unfamiliar bedroom such as a hotel/motel room?	Yes	No	
Do you have an aching, uncomfortable or squirmy sensation in your legs which keep you from sleeping?	Yes	No	
For how long have you had problems with insomnia?	Yes	No	N/A

**SLEEP HYGIENE**

Do you eat before bed?	Yes	No
Do you have a desk in you bedroom?	Yes	No
Do you sleep with the TV on?	Yes	No
Do you sleep with a child or animal in your bed?	Yes	No
Do you sleep with lights on or open windows?	Yes	No
Do you have an exercise program?	Yes	No
Do you sleep in a cool bedroom?	Yes	No

**SLEEP RELATED MOVEMENT DISORDER (Restless legs/Periodic Limb Movements):**

Do you have an unpleasant sensation in your legs associated with an irresistible urge to move?	Yes	No
Does the urge to move/unpleasant sensation begin or worsen during inactivity?	Yes	No
Do you have unpleasant sensations in the limbs that go away with movement?	Yes	No
Do you have unpleasant sensations/urge to move your limbs in the evening/night?	Yes	No
Do you kick or jerk your legs during the day/evening/while asleep?	Yes	No
Do you grind your teeth at night or have been diagnosed with TMJ?	Yes	No

**PARASOMNIA**

Do you act out vivid violent dreams?	Yes	No
Do you ever arouse from sleep confused?	Yes	No
Have you ever hurt yourself or others during sleep?	Yes	No
Have you had arousals during sleep of which you have no memory?	Yes	No
Have you done strange things during sleep during times of stress?	Yes	No
Do you sleepwalk without remembering it?	Yes	No
Do you cry out or scream during sleep?	Yes	No
Do you act out your dreams and are you able to recall them?	Yes	No

Patient Name: \_\_\_\_\_

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

**EXCESSIVE DAYTIME SLEEPINESS**

Are you sleepy or tired all day?	Yes	No
Do you fall asleep watching TV or reading?	Yes	No
Have you fallen asleep at inappropriate or unexpected times such as meetings, conversations, or social gatherings?	Yes	No
Have you had accidents or near accidents because of sleepiness?	Yes	No
Have you "come to" or suddenly become alert and found yourself doing things without being aware of having started them or remembering how you got there?	Yes	No
Have you experienced sudden weakness in the Legs, arms, face, neck or body in general, while awake, perhaps after laughing at a joke, or after being surprised, angry or upset?	Yes	No
Have you had hallucinations or dream like images while awake?	Yes	No
Do you take naps during the day?	Yes	No
How many days per week?	_____	
How long are the naps?	_____	
Are they refreshing?	Yes	No
Do you dream during your naps?	Yes	No
Did you fall asleep, or fight the urge to fall asleep in school as a child or adolescent?	Yes	No
Have you ever felt unable to move upon going to sleep or awakening?	Yes	No
I f Yes to any of the above, have symptoms been present for > 3 months?	Yes	No

**Spouse, Roommate, or Bed partner Questionnaire:**

**IMPORTANT!**

*(\*\*\*to be filled out about **you** by your spouse, roommate, or bed partner— not about your spouse, roommate, or bed partner)*

Does he/she snore?	Y	N
Does he/she stop breathing?	Y	N
Do his/her legs or body twitch or kick?	Y	N
Does he/she grind his/her teeth?	Y	N
Does he/she walk in his/her sleep?	Y	N
Does he/she sit up in bed while not awake?	Y	N
Does he/she become rigid or shake during sleep?	Y	N
Does he/she rock or bang his/her head during sleep?	Y	N

Other observations:

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Patient Name: \_\_\_\_\_

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

**Epworth Sleepiness Scale:**

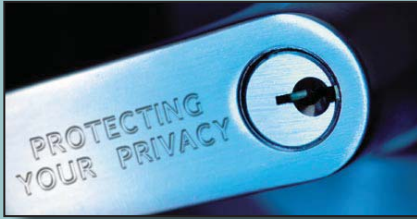
How likely are you to doze off in the following situations (in contrast to just feeling tired)? Even if you have not done some of these things, try to work out how these situations would affect you. Use the following scale:

- 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	_____
Total	_____

**Fatigue severity scale:**

	Disagree ← → Agree
1. My motivation is lower when I am fatigued	1 2 3 4 5 6 7
2. Exercise brings on fatigue	1 2 3 4 5 6 7
3. I am easily fatigued	1 2 3 4 5 6 7
4. Fatigue interferes with my physical functioning	1 2 3 4 5 6 7
5. Fatigue causes frequent problems for me	1 2 3 4 5 6 7
6. My fatigue prevents sustained physical functioning	1 2 3 4 5 6 7
7. Fatigue interferes with carrying out responsibilities	1 2 3 4 5 6 7
8. Fatigue is among my three most disabling symptoms	1 2 3 4 5 6 7
9. Fatigue interferes with work, family, or social life	1 2 3 4 5 6 7



# HIPPA PRIVACY AUTHORIZATION

## HIPPA PRIVACY AUTHORIZATION FOR USE AND DISCLOSURE OF PERSONAL HEALTH INFORMATION

This authorization is prepared pursuant to the requirements of the Health Insurance Portability and Accountability Act of 1996 (collectively known as HIPPA).

Our notice of Privacy Policy provides more detailed information about how we may use and disclose your protected health information. You have the right to review our Notice of Privacy Policy before you sign this consent.

We reserve the right to change the terms of our Notice of Privacy Policy. You obtain a copy of the current notice by requesting it from our staff.

You have the right to request us to restrict how we use and disclose your protected health information for the purpose of treatment, payment or health care operations. We are not required to grant your request, but if we do, the restriction will be binding on us.

You may revoke this consent at any time. Your revocation must be in writing, signed by you or on your behalf, and delivered to us, either personally or by mail. It will be effective when we actually receive it.

**I hereby give consent to Helmuth T. Billy M.D., or Andrew S. Binder M.D. to use and disclose my protected health information for the purpose of treatment payment and health care operations.**

Patient signature: \_\_\_\_\_ Date: \_\_\_\_\_  
Print name of patient: \_\_\_\_\_ Date: \_\_\_\_\_

If you are signing as the patient's representative:

Print your name: \_\_\_\_\_ Date: \_\_\_\_\_  
Describe your authority: \_\_\_\_\_

### Revocation

**I hereby revoke the consent given above.**

Patient signature: \_\_\_\_\_ Date: \_\_\_\_\_  
Print name of patient: \_\_\_\_\_ Date: \_\_\_\_\_

If you are signing as the patient's representative:

Print name: \_\_\_\_\_ Date: \_\_\_\_\_  
Describe your authority: \_\_\_\_\_