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.

VENTURA OFFICE
3200 Telegraph Road
Ventura, CA 93003

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.

Ventura Advanced Surgical Associates

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.

We schedule our appointments so that each patient receives the right amount of time to be seen by Dr. Billy and clinicians. That's why it is very important that you keep your scheduled appointment with us and arrive on time.

If your schedule changes and you cannot keep your appointment, please contact us so we may reschedule you, and accommodate those patients who are waiting for an appointment. As a courtesy to our office as well as to those patients who are waiting, please contact us at least 24 hours in advance.

If you do not cancel or reschedule your appointment with us, there is a $25 "no-show" service charge added to your account. This "no-show" charge is not reimbursable by your insurance company. You will be billed directly for it.

PATIENT NAME:_____

SIGNATURE:_____

DATE _____

VENTURA OFFICE
3200 Telegraph Road
Ventura, CA 93003

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.

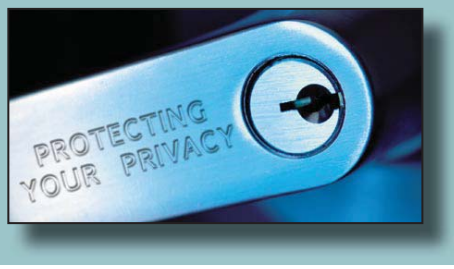
4. Returned checks and balances older than 45 days may be subject to additional collection fees and interest charges of 2 1/2 percent per month.

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_____

VENTURA OFFICE
3200 Telegraph Road
Ventura, CA 93003



HIPPA PRIVACY AUTHORIZATION

HIPPA PRIVACY AUTHORIZATION
FOR USE AND DISCLOSURE OFPERSONAL 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: _____

VENTURA OFFICE
3200 Telegraph Road
Ventura, CA 93003

Ventura Advanced Surgical Associates

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?_____

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:

FATHER AGE_____
LIVING____DEAD_____
CAUSE OF DEATH_____
_____
ANY MEDICAL PROBLEMS?_____
_____

MOTHER AGE_____
LIVING____ DEAD_____
CAUSE OF DEATH_____
_____
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
Brothers	_____	____	_____	_____	_____
	_____	____	_____	_____	_____
	_____	____	_____	_____	_____
Sisters					
	_____	____	_____	_____	_____
	_____	____	_____	_____	_____
	_____	____	_____	_____	_____

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.

_____

_____

_____

_____

_____

_____

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.

Name:_____
Address: _____
Phone: _____

I see the following specialists

Name:_____
Address: _____
Phone: _____

I see the following specialists

Name:_____
Address: _____
Phone:

I see the following specialists

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 chocking with regurgitations? _____ How often? _____

Do you ever regurgitate solid food? _____ What time of day dose 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 Please list in Chronologic order	Weight Loss Episode / Attempt What kind? Supervised? By whom? Medicine?	Beginning Weight	Amount of Weight Lost	Over How Many Months	Weight gained Back?	Over How Long?

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

Do you wake up during the night? Yes No
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
or while falling asleep?	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
If 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:

_____
_____
_____
_____
_____

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