

DATE: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

# Michael F Sedrak A Medical Corporation

License#: A82582, TaxID#: 20-8149126, NPI#: 1750464111

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

10336 Wilshire Blvd #602 Los Angeles, CA 90024

BIRTHDATE: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Ph#: (310)728-0494, Fax#: (559)553-8874

## BED PARTNER QUESTIONNAIRE

Please ask someone who has watched you sleep to complete this form.

Observer's Name: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_ Date: \_\_\_\_\_

I have observed this person's sleep:  once or twice  often  almost every night

**Check** any of the following behaviors that you have observed this person doing while asleep. **Circle** those that you consider severe problems for this person.

light snoring  
loud snoring  
loud snorts  
pause in breathing (how long? \_\_\_\_\_seconds  
choking  
gasping for air  
twitching, moving or kicking of legs  
twitching or flinging of arms  
grinding teeth

sleep talking  
sitting up in bed not awake  
getting out of bed not awake  
head rocking or banging  
awakening with pain  
becoming very rigid and/or shaking  
biting tongue  
crying out  
apparently sleeping even if he/she behaves otherwise

If snores, what makes it worse? sleeping on back alcohol sleeping on side fatigue

Does snoring sometimes require you or your partner to sleep separately? Y  N

Does this person drink alcohol or use street drugs? Y  N

### Modified Epworth Sleepiness Scale

As an observer, please complete the following information in your estimation of the chances of his/her dozing in the following situations. (Even if none of these things have occurred recently, try to work out how they would have affected him/her.) Use the scale below 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

	0	1	2	3
Sitting and reading	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Watching TV	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sitting, inactive in a public place (e.g., a theater)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
As a passenger in a car for an hour without a break	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lying down to rest in the afternoon when circumstances permit	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sitting and talking to someone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sitting quietly after lunch without alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
In a car, while stopped for a few minutes in traffic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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### HIPAA NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

This notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operation's (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected Health Information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

#### Uses and disclosures of protected health information

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

**Treatment:** We will use and disclose your protected health information to provide, coordinate or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnosis or treat you.

**Payment:** Your protected health information will be used, as needed, to obtain payment for your healthcare services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

**Healthcare Operations:** We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In additions, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law.

You may revoke the authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

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### Your Rights

Following is a statement of your rights with respect to your protected health information.

#### **You have the right to inspect and copy your protected health information.**

Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

#### **You have the right to request a restriction of your protected health information.**

This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in the Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

**You have the right to request to receive confidential communication from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us,** upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

**You may have the right to have your physician amend your protected health information.** If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

**You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.**

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

### Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filling a complaint.

This notice was published and becomes effective on/or before **April 14, 2003**.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPPA Compliance Officer in person or by phone at our Main Phone Number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Observer's Name: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_ Date: \_\_\_\_\_

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**PATIENT SIGNATURE :**

\_\_\_\_\_

Date

\_\_\_\_\_

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## PATIENT DEMOGRAPHICS

All information will be confidential. In order to serve you properly, we request the following information:

Patient name (last, first): \_\_\_\_\_ Male  Female

How did you hear about us?  Physician  Referred by:

Website/Internet  Yellow Pages  Television/Radio  Magazine/Newspaper

Insurance Co.  Patient/Friend  Other:

DOB: \_\_\_\_\_ SSN: \_\_\_\_\_

Email address: \_\_\_\_\_

Home phone: \_\_\_\_\_ Work phone: \_\_\_\_\_

Cell phone: \_\_\_\_\_ Alt phone: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Emergency contact name (last, first): \_\_\_\_\_

EC Phone: \_\_\_\_\_ EC Relationship: \_\_\_\_\_

- I authorize release of any information concerning my health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits.
- I authorize the release to my DME provider or referring/consulting/primary care physician of any information that may be needed.
- I authorize SVSC to obtain a photograph for my medical records.
- I hereby authorize all payments of insurance benefits to go directly to SVSC or practitioner even if it is made payable to me. I understand that any allowed charges not fully paid by my insurance will be my responsibility and will be billed accordingly.
- I authorize the sleep center staff to perform necessary service I may need.
- I acknowledge that I have been given the option to read the SVCS "Notice of Privacy Practices".

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

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

DATE: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

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**RECORDS RELEASE AUTHORIZATION**

I HEREBY AUTHORIZE AND REQUEST YOU TO RELEASE MY MEDICAL RECORDS TO:

Michael F Sedrak A Medical Corporation  
10336 Wilshire Blvd #602 Los Angeles, CA 90024  
Ph#: (310)728-0494, Fax#: (559)553-8874

I HEREBY AUTHORIZE AND REQUEST RELEASE OF MY MEDICAL RECORDS FROM:

Michael F Sedrak A Medical Corporation  
10336 Wilshire Blvd #602 Los Angeles, CA 90024  
Ph#: (310)728-0494, Fax#: (559)553-8874

TO/FROM \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

THE LATEST HISTORY AND PHYSICAL IN YOUR POSSESSION CONCERNING MY ILLNESS.

NAME \_\_\_\_\_ SS# \_\_\_\_\_

DOB \_\_\_\_\_

ADDRESS \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

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## SLEEP AND MEDICAL HISTORY

Today's Date: \_\_\_\_\_

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Primary MD: \_\_\_\_\_

DOB: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Referring MD: \_\_\_\_\_

It is important for you to be as accurate as possible in answering the following questions. The purpose of this questionnaire is to get a total picture of your background and the nature of your present problem. Please complete these questions **as thoroughly as you can**.

**All answers should refer to a typical night (or day) of sleep.**

***If you are already using CPAP, answer according to when you are wearing the mask.***

### Annotate your main problem(s):

- Act out dreams     Hard to fall asleep     Hold breath when sleeping     Snore     Too tired  
 Gasp or Choke     Hard to stay asleep     Legs kick/move     Too sleepy     Usually feel un-rested  
 Other: \_\_\_\_\_

### General Sleep:

1. For how long have you had this problem?

- Only within the last month     1-6 months     6 months – 2 years     > 2 years

2. Rate the severity of your problem.

- Mild     Moderate     Severe     the problem is only for others

3. Is it getting worse?

- No     Yes     Do not know

5. Does your sleep problem negative impact

- ...your work performance?     No     Yes  
...your sex life?     No     Yes  
...your quality of life?     No     Yes  
...your social activity?     No     Yes

6. Do any other members of your family have significant sleep problems?

- No     Yes

If yes, please explain: \_\_\_\_\_

7. Do you use any medication or other substance to help you sleep?

- No     Yes

If yes, please list name, dose, frequency, length of usage: \_\_\_\_\_

8. Have you ever discussed these sleep problems with another doctor?

- No     Yes... Dr. Name: \_\_\_\_\_ Diagnosis: \_\_\_\_\_

List **present** sleep treatment: \_\_\_\_\_ Date started: \_\_\_\_\_

List **prior** sleep treatment: \_\_\_\_\_ Dates: \_\_\_\_\_



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## SLEEP AND MEDICAL HISTORY

**N** = Never      **O** = Occasionally      **F** = Frequently

**Please rate how often you or others have noted that you:**

	<b>N</b>	<b>O</b>	<b>F</b>
Snore .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Snore loudly enough that others complain .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Awaken from sleep feeling short of breath, gasping, or choking .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hold your breath or stop breathing while asleep .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Experience other breathing problems at night .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have headaches upon waking that improve in less than 2 hours .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have dry mouth upon waking .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sweat excessively at night .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Experience heart pounding or beating irregularly during the night .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<hr/>			
Feel sleepy or tired during the day .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Awaken feeling unrested or unrefreshed .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Get sleepy while driving .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have had a wreck due to sleepiness .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have trouble at work or school because of sleepiness .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Become irritable or "crabby" .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Experience decrease in memory or concentration abilities .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<hr/>			
Fall asleep involuntarily or suddenly or in awkward situations .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Experience sudden weakness, buckling of knees or facial heaviness when laughing, scared, angry or crying .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Feel totally unable to move (paralyzed) when first waking or falling asleep .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Experience vivid dreamlike scenes, smells or sounds upon waking or falling asleep (similar to hallucinations) .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Find yourself doing complex tasks of which you were totally unaware (such as driving/navigating without conscious awareness) .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<hr/>			
Have nightmares or night terrors .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Act out your dreams .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Walk in your sleep .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do anything else considered "unusual" while asleep .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<hr/>			
Recurrently or rhythmically move, twitch or jerk your legs <b>while asleep</b> .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Feel restlessness, agitation or discomfort in your legs <b>at or before bedtime</b> .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**If so.....**

Do you feel an overwhelming urge to move your legs? .....	<b>Y</b> <input type="checkbox"/>	<b>N</b> <input type="checkbox"/>
Does it happen only in the evening? .....	<b>Y</b> <input type="checkbox"/>	<b>N</b> <input type="checkbox"/>
Does it happen only when relaxed? .....	<b>Y</b> <input type="checkbox"/>	<b>N</b> <input type="checkbox"/>
Does it get better if you move about or walk? .....	<b>Y</b> <input type="checkbox"/>	<b>N</b> <input type="checkbox"/>
Does it disturb sleep or sleep onset? .....	<b>Y</b> <input type="checkbox"/>	<b>N</b> <input type="checkbox"/>

How often do you experience this? \_\_\_\_\_ days per **week** or **month** (circle one)

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## SLEEP AND MEDICAL HISTORY

### Sleep Hygiene:

1. Do you often have anxiety (worry about things) around bedtime? ..... **Y**  **N**
  2. Do you often feel sad or depressed? ..... **Y**  **N**
  3. Do you sleep better away from home than in your own bed? ..... **Y**  **N**
  4. Do you have thoughts racing through your mind while trying to go to sleep? ..... **Y**  **N**
  5. Do you get anxious or upset when you are unsuccessful with falling asleep? ..... **Y**  **N**
  6. Do you usually take coffee, tea, or chocolate within 2 hours before you go to bed? ..... **Y**  **N**
  7. Do you do physical exercise within 2 hours before bedtime? ..... **Y**  **N**
  8. Do you watch TV or read in bed before falling asleep? ..... **Y**  **N**
  9. Do you ever sleep, nap, or rest during the awake portion of your day? ..... **Y**  **N**
- If yes... how often? \_\_\_\_\_ # per day \_\_\_\_\_ total per week
- ...on average, how long is your nap?  less than 1 hr  1 hr or more
- ...after a nap do you still remain tired? ..... **Y**  **N**

10. Check any condition that routinely applies to you:
  - sleep with someone else in your bed  sleep with a pet in your room  sleep by yourself
  - provide assistance to someone during the night (child, invalid, bed partner, animal)

11. Check any factors that disturb your sleep:
  - heat  cold  light  noise  bed partner  other: \_\_\_\_\_

### Sleep Habits:

12. You feel your best during  Morning  Afternoon  Evening
13. Estimate your total actual **sleep per night**? (do not include time awake in bed)
14. What time do you **usually go to bed**? on **WORKDAYS**? \_\_\_\_\_ on **NON-WORKDAYS**? \_\_\_\_\_
15. What time do you **usually rise from bed**? on **WORKDAYS**? \_\_\_\_\_ on **NON-WORKDAYS**? \_\_\_\_\_
16. How long does it **usually** take you to **fall asleep**? \_\_\_\_\_
17. How many hours of sleep do you feel you **need** in order to feel your very best? \_\_\_\_\_
18. In a perfect world, what would be your choice for an **ideal hour** to go to bed? \_\_\_\_\_ To awaken? \_\_\_\_\_
19. In your opinion, what usually **prevents** you from quickly falling to sleep? \_\_\_\_\_
20. How many times do you **typically wake up** at night? \_\_\_\_\_ Cause? \_\_\_\_\_
21. If you wake up, **on the average**, how long do you **stay awake**? \_\_\_\_\_
22. If you do awaken during the night, in which part(s) of your sleep period is it predominantly?
  - soon after falling asleep  middle of the night  near end of sleeping period

### Current Medications:

\*\*Please list **all** medicines **prescribed** by your doctor **and their dosages**\*\*

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DATE: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

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

BIRTHDATE: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

# Michael F Sedrak A Medical Corporation

License#: A82582, TaxID#: 20-8149126, NPI#: 1750464111

10336 Wilshire Blvd #602 Los Angeles, CA 90024

Ph#: (310)728-0494, Fax#: (559)553-8874

## MEDICAL HISTORY

### Past Medical History:

Please check any condition that a **doctor has diagnosed** you with

- |  |  |  |   |   |                                     |
|--|--|--|---|---|-------------------------------------|
| <b>Cardiac/Heart: (C)</b>                    | <b>Digestive: (D)</b>                          | <b>Endocrine/Other: (E)</b>                  | <b>Lung/Pulmonary: (L)</b>                | <b>Neurology: (N)</b>                                   | <b>Psychology: (P)</b>              |
| <input type="checkbox"/> Anemia              | <input type="checkbox"/> Acid Reflux (GERD)    | <input type="checkbox"/> Chronic Fatigue Syn | <input type="checkbox"/> Asthma           | <input type="checkbox"/> Headache                       | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Angina              | <input type="checkbox"/> Hiatal Hernia         | <input type="checkbox"/> Fibromyalgia        | <input type="checkbox"/> Bronchitis       | <input type="checkbox"/> Infection of Brain/Spinal Cord | <input type="checkbox"/> Anxiety    |
| <input type="checkbox"/> CHF (Heart Failure) | <input type="checkbox"/> Other Digestive Probs | <input type="checkbox"/> Thyroid Disease     | <input type="checkbox"/> COPD             | <input type="checkbox"/> Injury of Brain/Spinal Cord    |                                     |
| <input type="checkbox"/> Heart Attack        |  | <input type="checkbox"/> Cancer              | <input type="checkbox"/> Emphysema        | <input type="checkbox"/> Seizure/Epilepsy               |                                     |
| <input type="checkbox"/> Other Heart Problem |  |  | <input type="checkbox"/> Other Lung Prob. | <input type="checkbox"/> Other Brain/Nerve Disorders    |                                     |
- Other: \_\_\_\_\_

### Medication Allergies:

Are you allergic to any medications? (Please list)

\_\_\_\_\_

### Past Surgical History:

Please list any operations and approximate date of surgery (head or neck only)

Date	Type of Surgery	Date	Type of Surgery
_____	_____	_____	_____
_____	_____	_____	_____

### Family History:

Has anyone in your **blood-related** family ever been afflicted with:

- |   |   |  |  |
|---|---|--|--|
| <input type="checkbox"/> Act out dreams | <input type="checkbox"/> Excessive Sleepiness | <input type="checkbox"/> Narcolepsy    | <input type="checkbox"/> Sleep Walking |
| <input type="checkbox"/> Depression     | <input type="checkbox"/> Heart Attack         | <input type="checkbox"/> Restless Legs | <input type="checkbox"/> Stroke        |
| <input type="checkbox"/> Diabetes       | <input type="checkbox"/> Hypertension         | <input type="checkbox"/> Sleep Apnea   | <input type="checkbox"/> Suicide       |

### Social History:

Marital Status:  S  M  D  W Occupation: \_\_\_\_\_

Please check all that apply:

- |                    |                                |   |                                       |                                     |                                    |
|--------------------|--------------------------------|---|---------------------------------------|-------------------------------------|------------------------------------|
| Alcohol            | <input type="checkbox"/> Never | <input type="checkbox"/> Rarely         | <input type="checkbox"/> Occasionally | <input type="checkbox"/> Frequently | <input type="checkbox"/> Alcoholic |
| Tobacco            | <input type="checkbox"/> None  | <input type="checkbox"/> Yes-type _____ | How much _____                        |                                     |                                    |
| Recreational Drugs | <input type="checkbox"/> None  | <input type="checkbox"/> Yes-type _____ | Frequency _____                       |                                     |                                    |

### Other:

Personal assessment of current health:  Poor  Fair  Good  Very Good  Excellent

Weight gain in the past 12 months:  None amt: \_\_\_\_\_ lbs

Weight loss in the past 12 months:  None amt: \_\_\_\_\_ lbs

Most you have ever weighed (non-pregnant): \_\_\_\_\_ lbs In what year? \_\_\_\_\_

<b>DOCTOR ONLY</b>
Today:
_____ lbs

DATE: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

## Michael F Sedrak A Medical Corporation

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### REVIEW OF SYSTEMS

Do you **presently**, or have you in the **recent past**, suffered from any of the listed items? (check all that apply)

#### ***Constitutional***

- Night Sweats
- Loss of Appetite
- Fatigue
- Weight Loss

#### ***Ear, Nose, Throat and Allergy***

- Trouble Breathing Through Nose
- Night Time Congestion
- Trouble Swallowing
- Hoarse Voice
- Frequent Nosebleed
- Swollen Glands
- Frequent Infections
- Frequent Hives
- Frequent Colds
- Nasal/Seasonal Allergies

#### ***Heart***

- Chest Pain While Awake
- Chest Pain While Asleep
- Very Rapid Heart Beat
- Irregular Heartbeat
- Leg Swelling
- Pains in Legs When Walking

#### ***Lungs***

- Chronic Cough
- Pain with Breathing
- Short of Breath with Mild Exertion
- Trouble Breathing Laying Flat

#### ***Genital/Urinary***

- Trouble with Erection
- Testicular Pain or Swelling

#### ***Musculoskeletal***

- Joint Pain or Swelling
- Back Pain (Chronic)
- Muscle Pain or Weakness
- Leg Cramps

#### ***Endocrine***

- Cold Intolerance
- Excessive Thirst
- Sexual Dysfunction

#### ***Psychiatric***

- Hallucinations
- Nightmares
- Feel Depressed
- Feel Nervous or Tense
- Suicidal Thoughts

#### ***Nervous System***

- Frequent Headaches
- Loss of Strength in Specific Body Area
- Loss of Feeling in Specific Body Area
- Fainting Spells
- Trouble with Balance
- Trouble with Coordination
- Dizziness
- Trouble Walking

DATE: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

**Michael F Sedrak A Medical Corporation**

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**EPWORTH SLEEPINESS SCALE**

How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired? This refers to your usual way of life in recent times. Even if you have not done some of these things recently, try to work out how they would have affected you. Use the following scale to choose the most appropriate number for each situation:

- 0 - would never doze
- 1 - slight chance of dozing
- 2 - moderate chance of dozing
- 3 - high chance of dozing

<b>Situation</b>	<b>Chance of Dozing</b>
Sitting and reading	_____
Watching TV	_____
Sitting, inactive in a public place (e.g. a theater or a meeting)	_____
As a passenger in a car for an hour without a break	_____
Lying down to rest in the afternoon when circumstances permit	_____
Sitting and talking to someone	_____
Sitting quietly after lunch without alcohol	_____
In a car, while stopped for a few minutes in traffic	_____
	<b>Total:</b> _____

DATE: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

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## POST SLEEP QUESTIONNAIRE

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

Date of Study \_\_\_\_\_

How comfortable were you about the study?  Comfortable  Ok  
 Not Comfortable  Very Uncomfortable

If you were on CPAP, how comfortable were you?  Comfortable  OK  
 Not Comfortable  Very Uncomfortable

Did you fall asleep easily after light were out?  Yes  No

Did you fall asleep easily after CPAP was started?  Yes  No

How long did it take you to fall asleep after light out? \_\_\_\_\_

How long did it take you to fall asleep after CPAP was started? \_\_\_\_\_

How does it compare to your usual sleep?  More sleep  Same sleep  
 Less sleep

Do you remember waking up last night?  Yes  No

IF yes, how many times? \_\_\_\_\_

Do you have any physical complaints?  Yes  No

IF yes, please explain \_\_\_\_\_

How do you feel right now?  Very tired  Awake but not alert  
 Rested  Wide awake and alert

If you remember your dream from last night, briefly describe it. \_\_\_\_\_

How were you treated by your technician?  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_