Southern California Pulmonary & Sleep Disorders Medical Center

Ronald A. Popper MD, FCCP, FAASM, DABSM
Medical Director

New Patient Information And Questionnaire

Revised May 1, 2024

317 S. Moorpark Rd • Thousand Oaks, CA 91361 • (805) 557-9930

PLEASE READ CAREFULLY

Instructions for Completing the New Patient Information and Questionnaire

The forms on the following pages were designed to be completed on your computer to preclude the need to print and fill them out by hand. These forms were created to work properly within the **Adobe Reader application** on both a PC and a Mac. If you attempt to fill out these forms in some other PDF reader application, the automated features that have been included for your convenience will not work properly. You may CLICK HERE to download the latest version of the free Adobe Reader application. Once it is installed on your computer, open the application and THEN open the document from inside the application.

As you move from page to page, please read the instructions for each questionnaire carefully and completely. Click inside the appropriate fields or boxes to enter your information and answer all questions as accurately as you can. If a page does not apply to you, please click the indicated box at the top.

Several pages will require a signature. If you click on the signature line, a box will open to allow you to affix your "digital signature." If you do not have a digital signature, you will be guided through the steps to create one. Click the "sign" button and another box will open asking you to save the document. Click "Save." When you click the save button, you will be informed that this document already exists and you will be asked if you want to replace it. Always answer "YES" to this question on your PC or "REPLACE" on your Mac.

The above steps will be necessary for every page that requires your signature. Please sign ALL PAGES that include a signature line. A page left unsigned will prevent your forms from being processed by our office and will delay your appointment and/or treatment.

If you are unable or choose not to create a digital signature, complete and save the forms on your computer, print out the entire package and manually sign all pages in the appropriate spaces.

***Once you have completed and saved this document**, you may click the* SUBMIT *button below to email it to our office, or you may print and deliver it by mail, fax or in person. If you have any difficulty completing this form or if the* SUBMIT *button does not work, please double check that you are using the **Adobe Reader** application. This form will only work properly in Adobe Reader.*

Submit Forms Package by Email

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Southern California Pulmonary & Sleep Disorders Medical Center, Inc.
Ronald A. Popper MD, FCCP, FAASM, DABSM, Medical Director
Phone (805) 557-9930 Fax (805) 557-9940 Website www.sleepmd4u.com
317 S. Moorpark Rd, Thousand Oaks, CA 91361

INSTRUCTIONS FOR NEW PATIENTS

Dear Patient:

You have requested or been referred for a consultation or a sleep study.

PLEASE FILL OUT ALL FORMS AND ANSWER ALL QUESTIONS COMPLETELY. PLEASE STATE "NONE" OR "NOT APPLICABLE (N/A)" RATHER THAN LEAVING AN ANSWER BLANK. PLEASE PRINT YOUR NAME AND DATE OF BIRTH AND SIGN ALL FORMS WHERE INDICATED.

YOUR GENERAL MEDICAL AND SLEEP QUESTIONNAIRES WILL BE PERSONALLY REVIEWED BY ME IN ADVANCE OF SCHEDULING YOUR APPOINTMENT TO HELP DETERMINE THE LENGTH OF TIME REQUIRED TO PERFORM YOUR CONSULTATION. YOUR COOPERATION IN ANSWERING ALL QUESTIONS AS THOROUGHLY AS POSSIBLE WILL GREATLY IMPROVE THE QUALITY OF YOUR VISIT AND ASSIST ME IN MAKING THE CORRECT DIAGNOSIS AND RECOMMENDING THE MOST APPROPRIATE TREATMENT FOR YOUR CONDITION.

If you have a spouse, significant other, bed partner or roommate, please have he or she assist you in filing out the Sleep Questionnaire. If there are differing opinions or answers to the questions, please write in the observing spouse, significant other, bed partner or roommate answers to the side of the question. If possible, please have your spouse, significant other, bed partner or roommate accompany you for your consultation.

ALL FORMS MUST BE COMPLETED AND RECEIVED BY OUR OFFICE BEFORE WE CAN SCHEDULE YOUR APPOINTMENT.

THANK YOU FOR YOUR COOPERATION.

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Date	**Account #**	**Driver's License #**
Last Name	**First Name**	**Middle Initial**
Home Street Address	**City**	**State** **Zip Code**
Birth Date	**Social Security #**	**Home Phone #** **Cell Phone #** **Email**
Marital Status **Single____ Married____ Divorced____ Widowed____ Separated____**		**Who referred you?** **If self referred, how did you find us?**
Emergency Contact	**Phone #**	**Relationship to you**
Your Employer	**Employer Address**	**Work Phone #**
PRIMARY INSURANCE INFORMATION **NAME AND ADDRESS**		
Insured Subscriber Name	**Subscriber #**	**Group Name**
Group #	**Insured Date of Birth**	**Insured Social Security #**
SECONDARY INSURANCE INFORMATION **NAME AND ADDRESS**		
Insured Subscriber Name	**Subscriber #**	**Group Name**
Group #	**Insured Date of Birth**	**Insured Social Security #**
PLEASE PROVIDE THE NAME AND LOCATION OF YOUR PHARMACY :		

I HEREBY AUTHORIZE ALL INSURANCE BENEFITS TO BE PAID DIRECTLY TO SOUTHERN CALIFORNIA PULMONARY & SLEEP DISORDERS MEDICAL CENTER. I UNDERSTAND THAT I AM RESPONSIBLE FOR CHARGES AS DESIGNATED BY MY INSURANCE COMPANY / COMPANIES (SUCH AS DEDUCTIBLES, CO-PAYMENTS, ETC.). I AM ALSO RESPONSIBLE FOR ANY AND ALL CHARGES NOT COVERED BY INSURANCE AND FOR ANY FINANCE FEES INCURRED ON UNPAID BALANCES. I AUTHORIZE SOUTHERN CALIFORNIA PULMONARY & SLEEP DISORDERS MEDICAL CENTER TO RELEASE ANY INFORMATION TO MY INSURANCE COMPANY / COMPANIES WHEN REQUESTED BY THEM.

_____ _____

Signature Date

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PATIENT PAYMENT POLICY

1. **All co-payments are to be paid at the time of service.**
2. The Southern California Pulmonary & Sleep Disorders Medical Center will bill your primary insurer. If your policy allows, assignment of insurance benefits must be made to the Southern California Pulmonary & Sleep Disorders Medical Center. If your policy does not allow for assignment of benefits to the Southern California Pulmonary & Sleep Disorders Medical Center, then all charges for services rendered are due and payable on the day of service.
3. Once your primary insurer settles our claim and issues an Explanation of Benefits (EOB), the Southern California Pulmonary & Sleep Disorders Medical Center will either bill your secondary insurer (depending on whom your secondary insurance is with) or await payment by your secondary insurer. Once your secondary insurer settles our claim and issues an EOB, you will be billed for the balance.
4. If you do not have secondary insurance, once your primary insurer settles our claim and issues an Explanation of Benefits (EOB), the Southern California Pulmonary & Sleep Disorders Medical Center will bill you for the balance.
5. Once you have been billed for the balance, (your statement will say “Amount Due” at the bottom right) you will have a 30 day grace period from the date of your statement, to pay off your balance in full.
6. **After 30 days, you will be charged $10.00 every 30 days until the balance and penalties are paid in full.**
7. If it becomes necessary to institute collection proceedings against you for the outstanding balance, you will pay for any and all expenses incurred, including, but not limited to, reasonable attorney fees and/or any commission (against the balance owed) due to the collection agency
8. If you contact us within the 30 day grace period regarding the inability to pay your balance in full, the Southern California Pulmonary & Sleep Disorders Medical Center, may, at its discretion, arrange for payments to be made on the balance.

By signing below I acknowledge that I have received a copy of this policy, I have read it and I understand it and agree to the terms as stated above.

_____ _____

(Patient Signature) (Date)

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CANCELLATION POLICY

I, _____ , understand and agree to Dr. Popper's cancellation policy:

1. If I cannot make my scheduled appointment, I will make all reasonable attempts to cancel my appointment with an advance notice of **at least 24 hours** to allow another patient or patients to be scheduled in my appointment slot.

2. If I fail to cancel my appointment with at least 24 hours advanced notice and this results in the inability to fill my appointment time with another patient or patients, I agree to pay a cancellation fee of:
   A. $75.00 per 15 minutes of scheduled time.
   B. $400.00 for a sleep study, MWT or MSLT.

3. **I understand that this is not a fee that is billable to my insurance company and I am personally responsible for this charge.**

4. I understand that this policy is necessary due to the extended waiting time for appointments the loss of income due to your failure to cancel with at least a 24 hour notice and the high cost of running this medical practice.

5. Please be aware that **we do not frivolously charge patients for missed appointments**. If you have a legitimate reason for being unable to keep your appointment such as a death in the family or a medical illness, we accept these explanations. Our primary concern is for patients who **forget** their appointments, are **too busy** to keep their appointments or **change their mind** and fail to give us adequate time to fill their appointment time with another patient.

_____ _____
Signature Date

I, Ronald A. Popper, M.D., understand that your time is valuable too. I, in turn, pledge that pending unexpected emergencies, my office staff will make all reasonable attempts to contact you should we anticipate that we are running behind schedule or need to reschedule your appointment.

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Credit Card Authorization

By signing this form you give this office permission to charge your credit card account in the event that you:

- Do not cancel a new patient visit or consultation within the agreed upon 24 hour notice consideration or
- Have an outstanding balance that is over 31 days and have not made a payment arrangement with the office manager

Please complete the information below:

Account Type: Visa_____ MasterCard_____

Cardholder Name _____

Account Number _____

Expiration Date _____

CVV2 (3 digit number on back of Visa/MC) _____

Billing Address:_____

City_____ State_____Zip Code_____

Best phone to reach you: _____

Your email: _____

I authorize the Southern California Pulmonary & Sleep Disorders Medical Center, Inc. to charge the credit card indicated in this authorization form according to the terms outlined above. I certify that I am an authorized user of this credit card and that I will not dispute the payment with my credit card company; so long as the transaction corresponds to the terms indicated in this form.

_____ _____
Patient Signature Date

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CONSENT FOR MEDICAL RECORDS RELEASE

TO: _____

PLEASE RELEASE THE FOLLOWING MEDICAL RECORDS IN YOUR POSSESSION TO DR. POPPER AT THE ADDRESS OR FAX NOTED ABOVE:

- **History and Physical** _____
- **Consultations** _____
- **Hospital D/C Summary** _____
- **Sleep studies** _____
- **Laboratory test reports** _____
- **Operative reports** _____
- **Pathology reports** _____
- **X-ray reports** _____
- **PFT reports** _____
- **ABG reports** _____
- **Other** _____

UNLESS OTHERWISE SPECIFIED, PLEASE SEND ALL REQUESTED RECORDS IN YOUR POSSESSION.

THANK YOU.

Patient (print name) _____

Patient SS#: _____

Patient DOB: _____

Patient Address: _____

, , _____

Patient Signature: _____

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NOTICE OF PRIVACY PRACTICES

At our facility we have always kept your health information secure and confidential. A new law requires us to continue maintaining your privacy, to give you this notice and to follow the terms of this notice. This notice describes how your health information may be used and disclosed and how you can access this information. Please review it carefully.

The law permits us to use, disclose or share your health information:

1. To those involved in your treatment. For example, a review of your file by a specialist doctor whom we may involve in your care is permitted.
2. For payment of your services. For example, we may send a report of your progress to your insurance company.
3. For our normal healthcare operations. For example, one of our staff will enter your information into our computer.
4. With our business associates, such as an outside laboratory or radiology service. We have a written contract with each associate that requires them to protect your privacy.
5. To contact you. For example, we may send a reminder card or call you regarding an appointment. If you are not home, we may leave this information on our answering machine or with the person who answers the telephone.
6. To a family member or another person responsible for your care, in an emergency.
7. When required by law.

You have the right to:

1. Know of any uses of disclosures we make with your health information above and beyond normal uses
2. Transfer medical records to another practice. There may be fees associated with this transfer.
3. Request an amendment or change in your health information. You must make this request in writing. If you wish to include a statement in your file, please submit this in writing. We may or may not make the changes you request, but we will be happy to include your statement in your file. If we agree to amend or change your file, we will not remove or alter earlier documents but we will add the new information.
4. To receive a copy of this notice.

If this practice is sold, your information will become the property of the new owner.

Except as described above, this practice will not use or disclose your health information without your prior written authorization.

You may request in writing that we not use or disclose your health information as described above. We will let you know if we can or cannot fulfill your request.

If we change any of the details of this notice we will notify you of the changes in writing.

You may file a complaint with the Department of Health and Human Services, 200 Independence Avenue, S.W. Room 509F, Washington, DC. 20201. You will not be retaliated against for filing a complaint. However, before filing a complaint, or for more information regarding our health information policy, please contact our office manager.

By signing below, _____I acknowledge receipt of this notice.
Print Name

_____ _____
Patient Signature Date

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RECEIPT OF NOTICE OF PRIVACY PRACTICES

I HEREBY ACKNOWLEDGE THAT I HAVE RECEIVED A COPY OF THIS MEDICAL PRACTICE'S NOTICE OF PRIVACY PRACTICES.

I WOULD LIKE TO RECEIVE A COPY OF ANY AMENDED NOTICE OF PRIVACY PRACTICES BY:

1. email_____
2. fax @ _____
3. mail @ _____

Patient (Print Name):_____

Patient Signature: _____ Date: _____

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ELECTRONIC MEDICAL RECORDS (EMR) DISCLOSURE

In an effort to streamline the way doctors and patients can relay information to each other, the United States Department of Health and Human Services, DHHS, has begun a process with Medicare, as of January 1, 2011, to use Electronic Health Records, or EHR. This change will affect everyone who sees a physician, despite them using Medicare or not.

EHR programs store your information electronically for each physician you see, and as a doctor updates their notes, lab results, etc. in your electronic chart, that information can be shared with another physician remotely and is paperless. EHR programs, just like we do, treat your personal information with the utmost care and consideration. Your data is protected via both hardware and software firewalls, and is encrypted anytime information is transferred. This advanced form of security is mandated by the DHHS, and must be strictly adhered to by every EHR program to ensure the safety of every patient's data.

The goal of this process is that by 2014 all physicians in the country will be mandated to use an EHR program, and this will allow all physicians to quickly and effectively communicate about their patients. The other result of this will be that every patient will have access to their medical records at any time by logging into what they are referring to as "Patient Portal", which is essentially a website acting as a medium to grant you access to your files. For now, Patient Portal is not in operation, and they are still in the testing phases of the whole process. Our practice has decided to participate in their testing phase as the EHR program rolls out over the next few years, until mandatory in 2014.

As a result of participating, we are being asked by the DHHS to collect some additional information from all of our patients. This information is demographic related and is being requested for the sake of tracking and monitoring trends in diseases/conditions across the country, for example a genetic predisposition to develop sickle cell anemia.

YOU ARE NOT REQUIRED TO GIVE US INFORMATION ABOUT YOUR RACE, ETHNICITY, OR PREFERRED SPOKEN LANGUAGE. However if you are comfortable in disclosing it, the DHHS would be grateful. **Our office does, however, need to know how you prefer to be contacted about confidential information, so we can convey that information to you in the best way possible for you.**

What is your race? _____ What is your ethnicity? _____

What is your preferred spoken language? _____

How do you prefer to be contacted with confidential information? _____
(e-mail, home phone, cell phone, or regular mail)

Patient (Print Name): _____

Patient Signature: _____ Date: _____

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Name: _____DOB: _____ Date: _____

What is the reason for your visit?

_____
_____
_____
_____
_____
_____
_____
_____
_____

Please list any past or current medical conditions and surgical procedures or state none:

Diagnosis	Date of onset	Diagnosis	Date of Onset

Please list all prescription and non-prescription medications, vitamins or supplements you take or state none:

Name of drug	Dosage	Times / Day	Name of drug	Dosage	Times / Day

ARE YOU ALLERGIC TO ANY MEDICATIONS? Yes ____ No ____ **IF YES, PLEASE LIST THE MEDICATIONS AND THE SPECIFIC REACTION TO EACH MEDICATION BELOW:**

_____ _____
_____ _____
_____ _____

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Name: _____DOB: _____ Date: _____

SOCIAL HISTORY:

Single ____ Married ____ Separated ____ Widowed ____ Divorced ____

Tobacco: Do you smoke? Yes ____ No ____ #Cigarettes / Day ____ How many years? ____

Did you smoke? Yes ____ No ____ #Cigarettes / Day ____ How many years? ____

When did you quit smoking? _____

Alcohol: Do you drink alcohol? Yes ____ No ____ #Drinks / Day ____

Did you drink alcohol? Yes ____ No ____ #Drinks / Day ____ When did you quit?_____

Recreational Drug Use: Have you in the past or do you currently use recreational drugs? Yes___ No___

If so, what did you use and when did you use recreational drugs?

_____

_____

Caffeine: Do you drink or consume caffeinated products (coffee, tea, soda or chocolate)? Yes___ No___

What Products and quantity do you consume daily?_____

_____

FAMILY HISTORY: Please include any history of High Blood Pressure, Heart Attack, Stroke, Diabetes, Cancer (type), Thyroid Disorder, Sleep Disorder (sleep apnea, restless limbs, insomnia)

Mother: Age ____ Living ____ Dead ____ Cause of Death _____

Other chronic medical conditions: _____

Father: Age ____ Living ____ Dead ____ Cause of Death _____

Other chronic medical conditions: _____

Siblings: Age (s) _____ Living ____ Dead ____ Cause of Death_____

_____

Other chronic medical conditions: _____

_____

Children: Age (S)_____ Living ____ Dead ____ Cause of Death _____

Other chronic medical conditions: _____

_____

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Name: _____DOB: _____ Date: _____

OCCUPATION: Please list your current occupation and all previous occupations including any military service and the approximate years at these occupations:

_____

REVIEW OF SYSTEMS: Please mark (x) any that apply chronically within the past 6 months.

General: Fevers___ Chills___ Sweating___ Change of appetite___ Unexpected change in weight___ Skin lesions or rash___ Swollen glands___

ENT: Headaches___ Earaches___ Sore throat___ Hoarseness___ Stuffy nose or post nasal drip___ Hay fever___

Respiratory: Cough___ Sputum production___ Spitting up blood___ Chest tightness___ Wheezing___ Shortness of Breath___

Cardiac: Chest pain___ Shortness of breath lying down compared with sitting up___ Awakening from sleep with shortness of breath___ Racing of your heart___ Swelling of your ankles___

Gastro-Intestinal: Abdominal pain___ Nausea___ Vomiting___ Diarrhea___ Constipation___ Change in bowel habits___ Vomiting blood___ Blood in your stool___ Pain or difficulty swallowing___ Reflux or heart burn___

Genito-Urinary: Burning or pain with urination___ Blood or pus with urination___ Difficulty starting or stopping urination___ Urinary frequency or hesitancy___ Slowness of urinary stream___ Passage of gravel or kidney stones___ Difficulty with erection or ejaculation___

Musculo-Skeletal: Chronic aches or pains___ New aches or pains___

Neurologic: Change in vision___ speech___ or hearing___ Coordination difficulty___ Numbness or tingling___ Weakness___ Head trauma___ Loss of consciousness___ Seizures ___

Psychiatric: Depression___ Anxiety___ Bipolar Disorder___ Other___

Have you ever had: Pneumonia___ Blood Clots in your legs or your lungs___ Exposure to TB___ High Blood Pressure___ Heart Attack___ Stroke___ Congestive Heart Failure___ Peptic Ulcer Disease___ Liver Disease___ Pancreatic Disease___ Diabetes___ Thyroid Disease___ Kidney Disease___ Seizures or Epilepsy___ Depression ___ Anxiety ___ Other Psychiatric Disorder ___

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Name: _____DOB: _____ Date: _____

SLEEP RELATED BREATHING / SLEEP APNEA QUESTIONS:

• Have you had previous sleep studies?	Yes___	No___
If yes, when and where? _____		
• Have you previously been diagnosed with sleep apnea?	Yes___	No___
• Are you currently being treated with APAP, CPAP or BiPAP?	Yes___	No___
IF YES, PLEASE ANSWER ALL QUESTIONS IN THIS SECTION AS YOU ARE ON TREATMENT		
• Do you snore?	Yes___	No___
• Are you aware of or have you been told that you stop breathing during sleep or awaken choking or gasping?	Yes___	No___
• Do you awaken with a dry mouth?	Yes___	No___
• Is your sleep restless and / or non-refreshing?	Yes___	No___
• Do you awaken during the night?	Yes___	No___
• Do you urinate at night?	Yes___	No___
• If so, how many times? _____	Yes___	No___
• Do you awaken with a headache?	Yes___	No___
• If so, how often? _____ per week or _____ per month		
• Do you awaken from sleep with heart burn or reflux?	Yes___	No___
• If so, how often? _____ times / sleep period / week / month		
• Are you fatigued or sleepy during the daytime?	Yes___	No___
• Do you take naps during normal waking hours?	Yes___	No___
• Do you fall asleep at inappropriate times?	Yes___	No___
• Do other family members have sleep apnea?	Yes___	No___
• What is your height _____ in inches and weight? _____ in pounds		

SLEEP RELATED MOVEMENT DISORDERS:

• Do you have an irresistible urge to move your extremities?	Yes___	No___
• Is the urge to move associated with unpleasant sensations such as pain, discomfort, numbness, tingling, burning, creepy-crawly, bugs on the skin or just an urge to move?	Yes___	No___
• Does the urge to move or unpleasant sensations begin or worsen during periods of inactivity?	Yes___	No___
• Does the urge to move or unpleasant sensations begin or worsen during the evening hours?	Yes___	No___
• Does the urge to move or unpleasant sensations lessen		
• during periods of activity?	Yes___	No___
• Do other family members have restless limb syndrome?	Yes___	No___

If you answered yes to any of the questions in the section on sleep related movement disorders, please answer the IRLS Rating Scale on page 18.

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Name: _____DOB: _____ Date: _____

INSOMNIA:

- Do you have difficulty falling asleep? Yes___ No___
- Do you have difficulty staying asleep? Yes___ No___

SLEEP SCHEDULE:

- What are your typical hours of work? _____
- What time do you eat dinner? _____
- What time do you get into bed? _____
- Are you sleepy or are you just tired or fatigued when you go to bed? _____
- What is your bed time on work / school days? _____
- What is your rise time on work / school days? _____
- What is your bed time on days off of work / school (usual if retired)? _____
- What is your rise time on days off of work / school (usual if retired)? _____
- If you had no work, school or social obligations, what time would you prefer to go to bed? _____
- If you had no work, school or social obligations, what time would you prefer to awaken? _____
- From the time you turn out the light with the intent of going to sleep, how long does it typically take you to fall asleep? _____
- If you awaken from sleep, what awakens you? _____
- If you awaken from sleep, do you have difficulty falling back asleep? Yes___ No___
- If you "sleep in", do you feel more rested than when you arise at your normal time? _____
- Do you deliberately nap? Yes___ No___
- If so, how often, at what time(s) and for how long? _____
- Do you fall asleep at inappropriate times? Yes___ No___

SLEEP HABITS:

- Do you have 30-60 minutes of relaxation or quiet before going to bed? Yes___ No___
- Do you do ☐work, ☐use your computer, ☐play video games, ☐talk on the phone, ☐text or ☐doing other stimulating activities right up until or near bedtime? Yes___ (Check all that apply) No___
- Do you ☐read or ☐watch TV in bed? Yes___ (Check all that apply) No___
- If you have difficulty falling or staying asleep
  - Are you anxious about your sleep? Yes___ No___
  - Do you worry how you will function the next day? Yes___ No___
  - Do you have a wandering mind? Yes___ No___
  - Do you tend to watch the clock? Yes___ No___
  - Do you stay in bed and try harder to fall asleep? Yes___ No___
  - Do you go into another room? Yes___ No___

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Name: _____DOB: _____ Date: _____

- Is your bedroom environment dark? Yes___ No___
- Is your bedroom environment quiet? Yes___ No___
- Is your bedroom environment at a comfortable temperature? Yes___ No___
- Is your bed comfortable? Yes___ No___
- Do you exercise regularly? Yes___ No___
- How often do you exercise? _____ What time do you exercise _____
- Do you use alcohol, sleeping pills or OTC sleep aids or supplements to help you fall asleep or stay asleep? (Circle all that apply) Yes___ No___ If yes how often? _____

NARCOLEPSY:

- Are you excessively sleepy during the daytime? Yes___ No___
- Do you have sudden, uncontrollable sleep attacks? Yes___ No___
- Do you fall asleep at inappropriate times or situations (while conversing, while driving or actively doing something? Yes___ No___
- Do you have hallucinations as you fall asleep or awaken from sleep? Yes___ No___
- Do you ever feel paralyzed as you fall asleep or awaken from sleep? Yes___ No___
- Do you experience sudden uncontrollable loss of muscle tone (blurry vision, slurred speech, weakness of an arm or leg or both or collapse to the ground) following strong emotions (laughter, anger, fright, orgasm)? Yes___ No___

THE EPWORTH SLEEPINESS SCALE

How likely are you to doze off 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

Please Click on the Most Appropriate Choice

	Chance of Dozing
Sitting and reading	0 1 2 3
Watching TV	0 1 2 3
Sitting, inactive in a public place (eg. a theater or a meeting)	0 1 2 3
As a passenger in a car for an hour without a break	0 1 2 3
Lying down to rest in the afternoon when circumstances permit	0 1 2 3
Sitting and talking to someone	0 1 2 3
Sitting quietly after a lunch without alcohol	0 1 2 3
In a car, while stopped for a few minutes in the traffic	0 1 2 3

Please add your numbers to get a total score **TOTAL SCORE = _____**

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FATIGUE SEVERITY SCALE (FSS)

Name:_____DOB_____DATE_____

Your age (years):_____ Your sex ☐ MALE ☐ FEMALE

The Fatigue Severity Scale is a method of evaluating the impact of fatigue on you. The FSS is a short questionnaire that requires you to rate your level of fatigue.

The FSS contains 9 statements that rate the severity of your fatigue symptoms. Read each statement and write down a number from 1 – 7, based on how accurately it reflects your condition during the past week and the extent to which your agree or disagree that the statement applies to you.

- A low value (eg., 1) indicates strong disagreement with the statement, whereas a high value (eg., 7) indicates strong agreement.
- It is important that you write down a number for every question.

FFS Questionnaire: **Strongly Disagree** **Disagree** **Unsure** **Agree** **Strongly Agree**
1 **2** **3** **4** **5** **6** **7**

ANSWER

During the past week, I have found that:

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

Please add your numbers to get a total score **TOTAL SCORE = _____**

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Name: _____DOB: _____ Date: _____

THE INTERNATIONAL RLS RATING SCALE

☐ This page does not apply to me.

Please rate your symptoms of RLS over the past 1-2 weeks based upon the following questions:

1. Overall, how would you rate the RLS discomfort in your legs or arms?
   _____Very Severe _____Severe _____Moderate _____Mild _____None

2. Overall, how would you rate the need to move around because of your RLS symptoms?
   _____Very Severe _____Severe _____Moderate _____Mild _____None

3. Overall, how much relief of your RLS arm or leg discomfort do you get from moving around?
   _____None _____Slight _____Moderate _____Complete _____No symptoms, does not apply

4. Overall, how sever is your sleep disturbance from your RLS symptoms?
   _____Very Severe _____Severe _____Moderate _____Mild _____None

5. How severe s your tiredness or sleepiness from your RLS symptoms?
   _____Very Severe _____Severe _____Moderate _____Mild _____None

6. Overall, how severe is your RLS as a whole?
   _____Very Severe _____Severe _____Moderate _____Mild _____None

7. How often do you get RLS symptoms?
   _____Very Severe _____Severe _____Moderate _____Mild _____None
   (6-7 days /week) (4-5 days /week) (2-3 days /week) (0-1 days/week)

8. When you have RLS symptoms, how severe are they on an average day?
   _____Very Severe _____Severe _____Moderate _____Mild _____None
   (>8 hrs /day) (3-8 hrs /day) (1-3 hrs / day) (< 1 hr /day)

9. Overall, how severe is the impact of your RLS symptoms on your ability to carry out your daily affairs, for Example, carrying out a satisfactory family, home, social, school or work life?
   _____Very Severe _____Severe _____Moderate _____Mild _____None

10. How severe is your mood disturbance from your RLS symptoms, for example, angry, depressed, sad, anxious or irritable?
    _____Very Severe _____Severe _____Moderate _____Mild _____None

SCORE 4 points for very severe; 3 points for severe; 2 points for moderate; 1 point for mild and 0 for none.

Please add your numbers to get a total score **TOTAL SCORE = _____**

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Insomnia Severity Index

☐ This page does not apply to me.

Name:_____**DOB**:_____**Date**:_____

The Insomnia Severity Index has seven questions. The seven answers are added up to get a total score. When you have your total score, look at the "Guidelines for Scoring / Interpretation" below to see where your sleep difficulty fits. For each question, please click the box next to the number that best describes your answer.

Please rate the CURRENT (i.e. LAST 2 WEEKS) SEVERITY of your insomnia problem(s).

Insomnia Problem	**None**	**Mild**	**Moderate**	**Severe**	**Very Severe**
1. **Difficulty falling asleep**	☐0	☐1	☐2	☐3	☐4
2. **Difficulty staying asleep**	☐0	☐1	☐2	☐3	☐4
3. **Problems waking up too early**	☐0	☐1	☐2	☐3	☐4

4. **How SATISFIED / DISSATISFIED are you with your CURRENT sleep pattern?**

Very Satisfied	Satisfied	Moderately Satisfied	Dissatisfied	Very Dissatisfied
☐0	☐1	☐2	☐3	☐4

5. **How NOTICEABLE to others do you think your sleep problem is in terms of impairing the quality of your life?**

Not at all	A Little	Somewhat	Much	Very Much
☐0	☐1	☐2	☐3	☐4

6. **How WORRIED / DISTRESSED are you about your current sleep problem?**

Not at all	A Little	Somewhat	Much	Very Much
☐0	☐1	☐2	☐3	☐4

7. **To what extent do you consider your sleep problem to INTERFERE with your daily functioning (e.g. daytime fatigue, mood, ability to function at work/daily chores, concentration, memory, mood, etc.) CURRENTLY?**

Not at all	A Little	Somewhat	Much	Very Much
☐0	☐1	☐2	☐3	☐4

Guidelines for Scoring / Interpretation:
Add the scores for all seven items = _____ your total score

Total score categories: 0–7 = No clinically significant insomnia 8–14 = Subthreshold insomnia
15–21 = Clinical insomnia (moderate severity) 22–28 = Clinical insomnia (severe)

A SCORE HIGHER THAN 14 INDICATES A CLINICALLY SIGNIFICANT INSOMNIA DISORDER AND WARRANTS FURTHER EVALUATION.