Medical History Form

Name: _____ Age:_____ Sex: M F

Family Provider: _____ Phone: _____

Present Status:

1. Are you in good health at the present time to the best of your knowledge? Yes No

2. Are you under a provider's care at the present time? Yes No
   If yes, for what? _____

3. Are you taking any medications at the present time? Yes No
   What: _____ Dosages: _____
   What:_____ Dosages: _____

4. Any allergies to any medications? Yes No
   _____

5. History of High Blood Pressure? Yes No

6. History of Diabetes? Yes No
   At what age: _____

7. History of Heart Attack or Chest Pain? Yes No

8. History of Swelling Feet Yes No

9. History of Frequent Headaches? Yes No
   Migraines? Yes No
   Medications for Headaches: _____

10. History of Constipation (difficulty in bowel movements)? Yes No

11. History of Glaucoma? Yes No

12. Gynecologic History:
    Pregnancies: Number: _____ Dates: _____
    Natural Delivery or C-Section (specify): _____
    Menstrual: Onset: _____
    Duration: _____
    Are they regular: Yes No
    Pain associated: Yes No
    Last menstrual period: _____
    Hormone Replacement Therapy: Yes No
    What: _____
    Birth Control Pills: Yes No
    Type: _____
    Last Check Up: _____

13. Serious Injuries: Yes No
    Specify: _____ Date: _____

14. Any Surgery: Yes No
Specify: _____ Date: _____
Specify: _____ Date: _____

15. Family History:

	Age	Health	Disease	Cause of Death	Overweight?
Father:					
Mother:					
Brothers:					
Sisters:					

Has any blood relative ever had any of the following:

Glaucoma: Yes No Who: _____
_____ Asthma: Yes No Who: _____
_____

Epilepsy: Yes No Who: _____
High Blood Pressure Yes No Who: _____
Kidney Disease: Yes No Who: _____
Diabetes: Yes No Who: _____
Tuberculosis: Yes No Who: _____
Psychiatric Disorder Yes No Who: _____
Heart Disease/Stroke Yes No Who: _____

Past Medical History: (check all that apply)

_____ Polio	_____ Measles	_____ Tonsillitis
_____ Jaundice	_____ Mumps	_____ Pleurisy
_____ Kidneys	_____ Scarlet Fever	_____ Liver Disease
_____ Lung Disease `	_____ Whooping Cough	_____ Chicken Pox
_____ Rheumatic Fever	_____ Bleeding Disorder	_____ Nervous Breakdown
_____ Ulcers	_____ Gout	_____ Thyroid Disease
_____ Anemia	_____ Heart Valve Disorder	_____ Heart Disease
_____ Tuberculosis	_____ Gallbladder Disorder	_____ Psychiatric Illness
_____ Drug Abuse	_____ Eating Disorder	_____ Alcohol Abuse
_____ Pneumonia	_____ Malaria	_____ Typhoid Fever
_____ Cholera	_____ Cancer	_____ Blood Transfusion
_____ Arthritis	_____ Osteoporosis	_____ Other: _____

___

Nutrition Evaluation:

1. Present Weight: _____ Height (no shoes): _____ Desired Weight: _____

2. In what time frame would you like to be at your desired weight? _____

3. Birth Weight: _____ Weight at 20 years of age: _____ Weight one year ago: _____

4. What is the main reason for your decision to lose weight? _____

5. When did you begin gaining excess weight? (Give reasons, if known): _____

_____

6. What has been your maximum lifetime weight (non-pregnant) and when?_____

7. Previous diets you have followed: Give dates, weight loss, compliance:

_____ _____

_____

_____ _____

8. Is your spouse, fiancee or partner overweight? Yes No

9. By how much is he or she overweight? _____

10. How often do you eat out? _____

11. What restaurants do you frequent?_____

12. How often do you eat "fast foods?"_____

13. Who plans meals? _____ Cooks? _____ Shops? _____

14. Do you use a shopping list? Yes No

15. What time of day and on what day do you shop for groceries? _____

16. Food allergies: _____

17. Food dislikes: _____

18. Food you crave: _____

19. Any specific time of the day or month do you crave food? _____

20. Do you drink coffee or tea? Yes No How much daily? _____

21. Do you drink cola drinks? Yes No How much daily? _____

_____

22. Do you drink alcohol? Yes No

What? _____ How much? _____ Weekly? _____

23. Do you use a sugar substitute? _____ Butter? _____ Margarine? _____

24. Do you awaken hungry during the night? Yes No

What do you do? _____

25. What are your worst food habits? _____

26. Snack Habits:

What? _____ How much? _____ When? _____

_____ _____ _____

27. When you are under a stressful situation at work or family related, do you tend to eat more? Explain:

_____

_____

28. Do you thing you are currently undergoing a stressful situation or an emotional upset? Explain:

_____

_____

29. Smoking Habits: **(answer only one)**

___ You have never smoked cigarettes, cigars or a pipe.
___ You quit smoking ____ years ago and have not smoked since.
___ You have quit smoking cigarettes at least one year ago and now smoke cigars or a pipe without inhaling smoke.
___ You smoke 20 cigarettes per day (1 pack).
___ You smoke 30 cigarettes per day (1-1/2 packs).
___ You smoke 40 cigarettes per day (2 packs).

30.

Typical Breakfast	Typical Lunch	Typical Dinner
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
Time eaten: _____	Time eaten: _____	Time eaten: _____
Where: _____	Where: _____	Where: _____
With whom: _____	With whom: _____	With whom: _____

31. Describe your usual energy level: _____

32. Activity Level: **(answer only one)**

___ Inactive−no regular physical activity with a sit-down job.
___ Light activity−no organized physical activity during leisure time.
___ Moderate activity−occasionally involved in activities such as weekend golf, tennis, jogging, swimming or cycling.
___ Heavy activity−consistent lifting, stair climbing, heavy construction, etc., or regular participation in jogging, swimming, cycling or active sports at least three times per week.
___ Vigorous activity−participation in extensive physical exercise for at least 60 minutes per session 4 times per week.

33. Behavior style: **(answer only one)**
    ____ You are always calm and easygoing.
    ____ You are usually calm and easygoing.
    ____ You are sometimes calm with frequent impatience.
    ____ You are seldom calm and persistently driving for advancement.
    ____ You are never calm and have overwhelming ambition.
    ____ You are hard-driving and can never relax.

34. Please describe your general health goals and improvements you wish to make: _____

_____

_____

_____

This information will assist us in assessing your particular problem areas and establishing your medical management. Thank you for your time and patience in completing this form.

Review of Systems

YES	NO	
___	___	Loss of hearing
___	___	Ringing in the ears
___	___	Ear infection
___	___	Bad vision
___	___	Eye pain
___	___	Eye infections
___	___	Nose bleeds
___	___	Sinus problems
___	___	Sore throat
___	___	Hoarseness
___	___	Shortness of breath
___	___	Back pain
___	___	Rash
___	___	Insomnia
___	___	Memory loss
___	___	Dizzy spells
___	___	Palpitations
___	___	Irregular pulse
___	___	Swelling
___	___	Fainting spells
___	___	Chest pain
___	___	Numbness
___	___	Loss of appetite
___	___	Indigestion
___	___	Diarrhea
___	___	Constipation
___	___	Bloody or tarry stools
___	___	Nervousness
___	___	Depression
___	___	Moodiness
___	___	Phobias
___	___	Hemorrhoids
___	___	Blood in urine
___	___	Frequent urination
___	___	Hernia
___	___	Sudden weight loss
___	___	Fatigue
___	___	Convulsions
___	___	Headache
___	___	Joint pain
___	___	Paranoia
___	___	Psychosis
___	___	Chemical Dependency
___	___	Cardiovascular Disease

Patient Informed Consent for Appetite Suppressants

I. Procedure And Alternatives:

1. I,_____ (patient or patient's guardian) authorize Dr. George C. Stege III to assist me in my weight reduction efforts. I understand my treatment may involve, but not be limited to, the use of appetite suppressants for more than 12 weeks and when indicated in higher doses than the dose indicated in the appetite suppressant labeling.

2. I have read and understand my provider's statements that follow:

> "Medications, including the appetite suppressants, have labeling worked out between the makers of the medication and the Food and Drug Administration. This labeling contains, among other things, suggestions for using the medication. The appetite suppressant labeling suggestions are generally based on shorter term studies (up to 12 weeks) using the dosages indicated in the labeling.
>
> "As a bariatric provider, I have found the appetite suppressants helpful for periods far in excess of 12 weeks, and at times in larger doses than those suggested in the labeling. As a provider, I am not required to use the medication as the labeling suggests, but I do use the labeling as a source of information along with my own experience, the experience of my colleagues, recent longer term studies and recommendations of university based investigators. Based on these, I have chosen, when indicated, to use the appetite suppressants for longer periods of time and at times, in increased doses.
>
> "Such usage has not been as systematically studied as that suggested in the labeling and it is possible, as with most other medications, that there could be serious side effects (as noted below).
>
> "As a bariatric provider, I believe the probability of such side effects is outweighed by the benefit of the appetite suppressant use for longer periods of time and when indicated in increased doses. However, you must decide if you are willing to accept the risks of side effects, even if they might be serious, for the possible help the appetite suppressants use in this manner may give."

3. I understand it is my responsibility to follow the instructions carefully and to report to the provider treating me for my weight any significant medical problems that I think may be related to my weight control program as soon as reasonably possible.

4. I understand the purpose of this treatment is to assist me in my desire to decrease my body weight and to maintain this weight loss. I understand my continuing to receive the appetite suppressant will be dependent on my progress in weight reduction and weight maintenance.

5. I understand there are other ways and programs that can assist me in my desire to decrease my body weight and to maintain this weight loss. In particular, a balanced calorie counting program or an exchange eating program without the use of the appetite suppressant would likely prove successful if followed, even though I would probably be hungrier without the appetite suppressants.

II. Risks of Proposed Treatment:

I understand this authorization is given with the knowledge that the use of the appetite suppressants for more than 12 weeks and in higher doses than the dose indicated in the labeling involves some risks and hazards. The more common include: nervousness, sleeplessness, headaches, dry mouth, weakness, tiredness,

psychological problems, medication allergies, high blood pressure, rapid heart beat and heart irregularities. Less common, but more serious, risks are primary pulmonary hypertension and valvular heart disease. These and other possible risks could, on occasion, be serious or fatal.

III. Risks Associated with Being Overweight or Obese:

I am aware that there are certain risks associated with remaining overweight or obese. Among them are tendencies to high blood pressure, to diabetes, to heart attack and heart disease, and to arthritis of the joints, hips, knees and feet. I understand these risks may be modest if I am not very much overweight but that these risks can go up significantly the more overweight I am.

IV. No Guarantees:

I understand that much of the success of the program will depend on my efforts and that there are no guarantees or assurances that the program will be successful. I also understand that I will have to continue watching my weight all of my life if I am to be successful.

V. Patient's Consent:

I have read and fully understand this consent form and I realize I should not sign this form if all items have not been explained, or any questions I have concerning them have not been answered to my complete satisfaction. I have been urged to take all the time I need in reading and understanding this form and in talking with my provider regarding risks associated with the proposed treatment and regarding other treatments not involving the appetite suppressants. I voluntarily agree to have one (1) prescribing provider for controlled substances, to use only one (1) pharmacy to fill prescriptions for controlled substances, not to have early refills on the prescriptions for controlled substances, and to provide full disclosure of other medications (narcotics) taken.

WARNING

IF YOU HAVE ANY QUESTIONS AS TO THE RISKS OR HAZARDS OF THE PROPOSED TREATMENT, OR ANY QUESTIONS WHATSOEVER CONCERNING THE PROPOSED TREATMENT OR OTHER POSSIBLE TREATMENTS, ASK YOUR PROVIDER NOW BEFORE SIGNING THIS CONSENT FORM.

DATE:_____ TIME:_____

PATIENT:_____WITNESS:_____
(or person with authority to consent for patient)

VI. PROVIDER DECLARATION:

I have explained the contents of this document to the patient and have answered all the patient's related questions, and, to the best of my knowledge, I feel the patient has been adequately informed concerning the benefits and risks associated with the use of the appetite suppressants, the benefits and risks associated with alternative therapies and the risks of continuing in an overweight state. After being adequately informed, the patient has consented to therapy involving the appetite suppressants in the manner indicated above.

_____

Provider's Signature

Weight Loss Program Consent Form

I _____ authorize Dr. George C. Stege III, Louisville Center for Weight Loss. and whomever they designate as their assistants, to help me in my weight reduction efforts. I understand that my program may consist of a balanced deficit diet, a regular exercise program, instruction in behavior modification techniques, and may involve the use of appetite suppressant medications. Other treatment options may include a very low calorie diet, or a protein supplemented diet. I further understand that if appetite suppressants are used, they may be used for durations exceeding those recommended in the medication package insert. It has been explained to me that these medications have been used safely and successfully in private medical practices as well as in academic centers for periods exceeding those recommended in the product literature.

I understand that any medical treatment may involve risks as well as the proposed benefits. I also understand that there are certain health risks associated with remaining overweight or obese. Risks of this program may include but are not limited to nervousness, sleeplessness, headaches, dry mouth, gastrointestinal disturbances, weakness, tiredness, psychological problems, high blood pressure, rapid heartbeat, and heart irregularities. These and other possible risks could, on occasion, be serious or even fatal. Risks associated with remaining overweight are tendencies to high blood pressure, diabetes, heart attack and heart disease, arthritis of the joints including hips, knees, feet and back, sleep apnea, and sudden death. I understand that these risks may be modest if I am not significantly overweight, but will increase with additional weight gain.

I understand that much of the success of the program will depend on my efforts and that there are no guarantees or assurances that the program will be successful. I also understand that obesity may be a chronic, life-long condition that may require changes in eating habits and permanent changes in behavior to be treated successfully.

I have read and fully understand this consent form and I realize I should not sign this form if all items have not been explained to me. My questions have been answered to my complete satisfaction. I have been urged and have been given all the time I need to read and understand this form.

If you have any questions regarding the risks or hazards of the proposed treatment, or any questions whatsoever concerning the proposed treatment or other possible treatments, ask your provider now before signing this consent form.

Date: _____ **Time:** _____

Witness: _____ **Patient:** _____

_____

(Or person with authority to consent for patient)

Welcome to our weight loss program! The program consists of three parts: diet, exercise, and medication.

Diet
We recommend a low fat reduced calorie diet. We will provide you with additional information on a low fat diet, and the provider will give you specific recommendations on how many fat grams you should eat each day. We do recommend three well balanced meals a day with no between meal snacking.

Exercise
We recommend aerobic exercise to help you lose weight. We recommend walking as the best exercise for most patients. The YMCAs offer excellent exercise programs. We recommend at least 30 minutes of aerobic exercise three times a week for cardiovascular fitness. If you are extremely overweight, water aerobics are another alternative.

Medication
Several types of appetite suppressants are available to assist you in losing weight. These medications will only suppress your appetite; to lose weight you must eat less. The provider will prescribe the one that is most appropriate for you. We have additional information on the medications available on request. The provider will answer any questions you have about the risk and benefits of using medication. In order to reach a healthy weight, it may be necessary to use medication in 'off-label' duration, indication, or combinations. Vitamins and other health supplements such as B12, B12 Lipo, and DHEA may be recommended that many people have found helpful but are without proven benefit. We do recommend daily multivitamins with vitamins A, B complex, C, D, E and K, and minerals calcium and iron.

In order to ensure your safety in taking any medication, it is important that we obtain a complete medical history and perform a physical exam. Some medical conditions such as high blood pressure or heart disease such as angina preclude the use of medication. Also, if you have a history of drug or alcohol abuse it is not safe for you to take medication. If you are pregnant or think you may be pregnant you must not take any medication. You must also let us know if you are allergic to any medication. You must not exceed the prescribed dose of any medication. Doing so would put you at risk of heart attack, stroke, or death. You also should check with the office before taking any over the counter medicine with prescription medication. You must let us know if you are taking any prescription medicine from any other providers. While participating in our diet program you must not see any other provider for similar medication as this may put you at risk for serious side effects or drug dependency and may be against the law. Regulations require that you fill your prescriptions at one pharmacy, and they can't be refilled early. Also be aware that it is against the law to sell or give your medication to any other person. If you have taken any diet medication in the past you must also inform us of this. We will provide you with copies of your lab results and EKG to take to your Primary Care Provider (PCP) for evaluation and treatment. Dr. Stege is a specialist board certified by the American Board of Bariatric Medicine. He will work with your PCP to help you. All blood test, urine tests, and EKGs will be given to you to take to your PCP for his evaluation and any necessary treatment. We recommend annual blood work. Dr Stege was also board certified in Family Practice by the American Board of Family Practice, and is a Fellow of the American Academy of Family Practice. While Dr. Stege may help you with refills or minor medical problems, he will not be functioning as your PCP unless specifically requested to do so in writing. Being overweight is a risk factor for sleep apnea and we recommend sleep studies if you are having any sleep difficulties.

To be eligible for medication you must be overweight. Being significantly overweight increases your risk of many serious medical problems. The provider will calculate your ideal weight based on your height, your frame size, and your percentage of body fat. You must also have tried to lose weight on your own first by diet and exercise for at least six months. I acknowledge that I have tried to lose weight on my own by diet and exercise for at least six months. To continue medication you must lose weight. If you experience any side effects or problems please call the office. Dry mouth, constipation, mild elevations of heart rate and slight nervousness are the most common side effects and are not of concern. Shortness of breath, chest pain, leg swelling, fainting spells, or elevated blood pressure should be reported immediately.

I have read all of the information above and agree to these terms.

_____ Date _____

NEW PATIENT MEDICAL INFORMATION

Date:_____

Name:_____

Age:_____

Do you have any medical problems?
- Î High blood pressure
- Î Diabetes
- Î Asthma

_____

_____

_____

Are you allergic to any medicines?
- Î Penicillin

_____

Have you had any surgeries?
- Î Appendix
- Î Gall Bladder
- Î Hysterectomy

Please list any medicines you take: _____

_____

Please list any hospitalizations: _____

Do any diseases run in your family?
- Diabetes
- High blood pressure
- Heart problems
- Cancer
- TB

Do you smoke? (No/ Yes) Drink? (No/ Yes)
Do you have a living will? (No/ Yes)
Are your immunizations up to date (No/ Yes)
Why are you here today? _____

_____

Please list any other symptoms or health concerns which you may be having:

_____

_____

PLEASE PRINT DATE:_____
Acct #:_____

PATIENT

Name: Date of birth: Telephone

Street Address: Apt: City: State: Zipcode:

Marital Status: Single Married Divorced Widowed Sex: Race:

Employer: Occupation: Social Security #:
Employer's Address: Work Telephone:
Preferred Language:

SPOUSE

Name: Date of Birth: Acct #:

Employer: Occupation: Social security #:

Employer Address: Work Telephone:

CHILDREN

Name: Date of Birth:

Name: Date of Birth:

Name: Date of Birth:

Name: Date of Birth:

IN CASE OF EMERGENCY CONTACT:

Name: Relationship: Work Phone: Home Phone:

Referred By: Î Provider Î Friend/Relative Î Telephone Book Î Other

Name: Address: Phone:

INSURANCE (Please present current insurance card to receptionist)

Primary Ins. Co: Policy No. Group No.

Claims Processing Address: Telephone

Insured's Name Relationship to Patient

Employer:

Comments:

Secondary Ins. Co: Policy No. Group No.

Claims Processing Address: Telephone

Insured's Name Relationship to Patient

Employer:

Comments:

Is this visit due to an employment-related or auto accident? Î Yes ÎNo

Date of Injury Nature and Location of Accident

PERMISSION FOR TREATMENT: Permission is hereby granted to George C. Stege, III, M.D., to render such medical and surgical treatment as is deemed necessary.

RELEASE OF INFORMATION: To the extent necessary to determine insurance benefits, liability for payment and to obtain reimbursement, George C. Stege 111, M.D. may disclose portions of the patient's medical record and account to any person or corporation which is or may be liable for all or any portion of the patient's charges including but not limited to insurance companies, health care service plans, or worker's compensation carriers. The patient's medical record may also be released to the referring provider to ensure continuity of medical care.

FINANCIAL AGREEMENT: In consideration of the services rendered to the patient, the undersigned agrees to accept full financial responsibility for the patient's account in accordance with the regular rates and terms of the facility. Should the account be referred for collections, the undersigned shall pay reasonable attorney's fees and collection expenses. Louisville Center for Weight Loss does not participate with any insurance companies and you are responsible for all charges. As a courtesy we will provide you with the information to file an out of network claim.

ASSIGNMENT OF INSURANCE BENEFITS: I request my insurance carrier to pay to George C. Stege, III, M.D. all benefits due me related to my pending claim for medical and surgical services.

MEDICARE S AUTHORIZATION: I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers, or to the billing agent of this provider or supplier, any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment.

I have read and approved all of the above except for those items I have personally lined through and initialed.

Signature of Insured/Guardian Date

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.

Uses and Disclosures

Treatment. Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

Payment. Your health information may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated.

Health care operations. Your health information may be used as necessary to support the day-to-day activities and management of the Practice. For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

Law enforcement. Your health information may be disclosed to law enforcement agencies to support government audits and inspections, to facilitate law-enforcement investigations, and to comply with government mandated reporting.

Public health reporting. Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

Other uses and disclosures require your authorization. Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision to revoke your authorization.

Additional Uses of Information

Appointment reminders. Your health information will be used by our staff to send you appointment reminders.

Information about treatments. Your health information may be used to send you information that you may find interesting on the treatment and management of your medical condition.. We may also send you information describing other health-related products and services that we believe may interest you.

Individual Rights

You have certain rights under the federal privacy standards. These include:

- the right to request restrictions on the use and disclosure of your protected health information
- the right to receive confidential communications concerning your medical condition and treatment
- the right to inspect and copy your protected health information
- the right to amend or submit corrections to your protected health information
- the right to receive an accounting of how and to whom your protected health information has been disclosed
- the right to receive a printed copy of this notice

the Practice Duties

We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices.

We also are required to abide by the privacy policies and practices that are outlined in this notice.

Right to Revise Privacy Practices

As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Upon request, we will provide you with the most recently revised notice on any office visit. The revised policies and practices will be applied to all protected health information we maintain.

Requests to Inspect Protected Health Information

You may generally inspect or copy the protected health information that we maintain. As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting the Receptionist or the Privacy Official. Your request will be reviewed and will generally be approved unless there are legal or medical reasons to deny the request.

Complaints

If you would like to submit a comment or complaint about our privacy practices, you can do so by sending a letter outlining your concerns to the Privacy Official.

If you believe that your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern. You will not be penalized or otherwise retaliated against for filing a complaint. This notice is effective 4/1/03.

Acknowledgement of Receipt of Notice of Privacy Practices

The Practice reserves the right to modify the privacy practices outlined in the notice.

Signature

I have received a copy of the Notice of Privacy Practices for Louisville Center for Weight Loss LLC and Hurstbourne Family Care LLC.

_____
Name of Patient (Print or Type)

_____
Signature of Patient

_____
Date

_____
Signature of Patient Representative
(Required if the patient is a minor or an adult who is unable to sign this form)

_____
Relationship of Patient Representative to Patient

Louisville Center for Weight Loss

2304 Hurstbourne Village Dr, Suite 500, Louisville, KY 40299 (502) 583-3191 581-1463 fax
www.drstege.com web drstege@drstege.com email

Sleep Quiz

Has anyone observed that you have stopped breathing while sleeping?
Yes __ No __

Do you snore loudly? Yes __ No __

Do you often feel tired, fatigued, or sleepy during the day? Yes __ No __

Do you often awake with a dry mouth? Yes __ No __

Do you frequently awaken with headaches? Yes __ No __

Do you have or are you being treated for high blood pressure? Yes __ No __

Do you often feel irritable or moody during the day? Yes __ No __

Are you currently gaining weight? Yes __ No __

Are you overweight? Yes __ No __

If you answered **YES to THREE** or more questions, you may have sleep apnea, a common yet serious condition that can result in poor sleep quality, daytime

fatigue, depression, irritability and memory problems. Left untreated, sleep apnea can also lead to heart disease and an increased risk of dangerous accidents.

Additionally, if you **SNORE and answered YES to any of the above and have a history of TIA, stroke, high blood sugar, or are taking medications for diabetes**, please discuss your significant risk of sleep apnea with your provider.