

PETRA TRAVNICEK, MD, FACP



NAME: \_\_\_\_\_ FIRST \_\_\_\_\_ MIDDLE \_\_\_\_\_ LAST \_\_\_\_\_

PRIMARY ADDRESS:

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

SECONDARY ADDRESS:

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

PHONE NUMBERS – PRIMARY: \_\_\_\_\_ HOME: \_\_\_\_\_

CELL: \_\_\_\_\_ CELL: \_\_\_\_\_

EMAIL: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_/\_\_\_\_/\_\_\_\_ SEX: \_\_\_\_\_

PREFERRED PHARMACY: \_\_\_\_\_ PHARMACY PHONE: \_\_\_\_\_

MARITAL STATUS: \_\_\_\_\_ SINGLE \_\_\_\_\_ MARRIED \_\_\_\_\_ DIVORCED \_\_\_\_\_ WIDOWED

CLOSEST RELATIVE: \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_ PHONE: \_\_\_\_\_

PERSON RESPONSIBLE FOR BILL: \_\_\_\_\_ REFERRED BY: \_\_\_\_\_

YOUR EMPLOYER: \_\_\_\_\_ PHONE: \_\_\_\_\_

WHEN CALLING WITH RESULTS, WITH WHOM MAY WE LEAVE THE INFORMATION:

\_\_\_\_\_

MAY WE LEAVE THE INFORMATION ON VOICEMAIL/ANSWERING MACHINE? \_\_\_\_ YES \_\_\_\_ NO

PERSON(S) WHO WILL ACT AS YOUR HEALTHCARE ADVOCATE IF THERE IS A NEED:

NAME: \_\_\_\_\_ PHONE: \_\_\_\_\_

DO YOU HAVE A SIGNED DNR? \_\_\_\_ YES \_\_\_\_ NO (IF YES, ATTACH COPY)

DO YOU HAVE ADVANCE DIRECTIVES? \_\_\_\_ YES \_\_\_\_ NO (IF YES, ATTACH COPY)

INSURANCE AUTHORIZATION AND ASSIGNMENT

I REQUEST THAT PAYMENT OF AUTHORIZED MEDICARE/OTHER INSURANCE COMPANY BENEFITS BE MADE TO MANASOTA MEDICAL GROUP, LLC FOR ANY SERVICES FURNISHED TO ME. REGULATIONS PERTAINING TO MEDICARE ASSIGNMENT OF BENEFITS APPLY. 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 CARRIES ANY INFORMATION NEEDED FOR THIS OR A RELATED MEDICARE/OTHER INSURANCE COMPANY 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 PARTY WHO ACCEPTS ASSIGNMENT. I UNDERSTAND IT IS MANDATORY TO NOTIFY THE HEALTH CARE PROVIDER OF ANY OTHER PARTY WHO MAY BE PAYING FOR MY TREATMENT. (SECTION 1128B OF THE SOCIAL SECURITY ACT AND 31 USC 3801-3812 PROVIDES PENALTIES FOR WITHHOLDING THIS INFORMATION.)

SIGNATURE (PRINT THEN SIGN DOCUMENT)

DATE

PETRA TRAVNICEK, MD, FACP



**INSURANCE AND FINANCIAL AGREEMENT  
ASSIGNMENT OF BENEFIT | PATIENT RESPONSIBILITY**

**INSURANCE PRE-CERTIFICATION**

I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY REQUIRED NOTIFICATION NEEDED BY MY INSURANCE COMPANY IN ORDER TO PAY FOR SERVICES RENDERED. IF THIS IS NOT DONE, MY BENEFITS MAY BE REDUCED AND I AM RESPONSIBLE FOR ALL NON-COVERED CHARGES.

**ASSIGNMENT OF BENEFITS**

I HEREBY ASSIGN TO MANASOTA MEDICAL GROUP ANY AND ALL BENEFITS FROM MY INSURANCE PLANS OR ANY OTHER PROTECTION MAINTAINED BY THE PATIENT. I AUTHORIZE AND DIRECT SUCH BENEFITS TO BE PAID DIRECTLY TO MANASOTA MEDICAL GROUP, FOR SERVICES PROVIDED. IF MY INSURANCE PLAN DOES NOT UPHOLD THE AGREEMENT TO PAY A CLAIM ON MY BEHALF WITHIN 30 DAYS OF FILING, I AUTHORIZE MANASOTA MEDICAL GROUP TO FILE A COMPLAINT TO THE INSURANCE COMMISSIONER IN ORDER TO REIMBURSE THEIR OFFICES.

**FINANCIAL AGREEMENT**

THE UNDERSIGNED GUARANTEES PROMPT PAYMENT OF ALL CHARGES FOR SERVICES RENDERED AT TIME OF SERVICE. ANY UNPAID BALANCE DUE BY PATIENT BEYOND 30 DAYS MAY BE TURNED OVER FOR COLLECTION.

**CONSENT FOR MEDICAL SERVICES**

I CONSENT TO TREATMENT, DIAGNOSTIC, AND / OR THERAPEUTIC SERVICES AS ORDERED AND / OR PROVIDED BY MANASOTA MEDICAL GROUP.

**CANCELLATION POLICY**

I UNDERSTAND THERE IS A 24 HOUR NOTICE TO CANCEL AN APPOINTMENT AND THAT I MAY BE CHARGED FOR CANCELING AN APPOINTMENT WITHOUT NOTICE.

**THE UNDERSIGNED CERTIFIES THAT HE/SHE HAS READ AND UNDERSTANDS THE ABOVE AND FULLY ACCEPTS ALL SPECIFIED TERMS THEREIN.**

\_\_\_\_\_  
SIGNATURE OF PATIENT OR AUTHORIZED LEGAL REPRESENTATIVE

\_\_\_\_\_  
DATE

(PRINT THEN SIGN DOCUMENT)



PETRA TRAVNICEK, MD, FACP



**PLEASE LIST THE MOST RECENT DATE YOU HAD ANY OF THESE TESTS / SERVICES**

NAME	DATE	NAME	DATE
ABDOMINAL AORTIC ULTRASOUND		HEMOCCULT STOOL CARDS	
ANNUAL PHYSICAL EXAM		MAMMOGRAM	
BONE DENSITY		MINI-MENTAL STATUS EXAM	
CARDIAC CATHETERIZATION		NEUROPSYCHOLOGICAL TESTING	
CAROTID ULTRASOUND		PAP	
CHEST X-RAY		PSA	
COLONOSCOPY		SPRIOMETRY TEST (BREATHING)	
ECHOCARDIOGRAM		STRESS TEST	
EKG		TB TEST	
EYE EXAM		UPPER ENDOSCOPY	
HEARING TEST			

**PLEASE LIST THE NAMES OF OTHER PHYSICIANS**

NAME	DR NAME	NAME	DR NAME
ALLERGY		OPHTHALMOLOGY	
CARDIOLOGY		ORTHOPEDICS	
DERMATOLOGY		OTOLARYNGOLOGY (ENT)	
GASTROENTEROLOGY		PAIN MANAGEMENT	
GYNECOLOGY		PODIATRY	
HEMATOLOGY		PRIMARY CARE	
NEUROLOGY		PULMONOLOGY	
NEPHROLOGY		PSYCHIATRY	
ONCOLOGY		UROLOGY	

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**PAST PERSONAL MEDICAL HISTORY**

<b>CONDITION</b>	<b>YEAR OF ONSET</b>	<b>ADDITIONAL COMMENTS</b>
HYPERTENSION		
DIABETES		
ANGINA		
HEART ATTACK		
STENT		
CORONARY BYPASS		
RHEUMATIC FEVER		
VALVULAR DISEASE		
MITRAL VALVE PROLAPSE		
CONGESTIVE HEART FAILURE		
PULMONARY EDEMA		
IRREGULAR RHYTHM		
ATRIAL FIBRILLATION		
PACEMAKER		
ASTHMA		
CHRONIC BRONCHITIS		
EMPHYSEMA (COPD)		
PNEUMONIA		
HIGH CHOLESTEROL		
CANCER: TYPE _____		
STROKE / TIA		
CATARACTS		
LENSES		
GLASSES		
LASIK SURGERY		
GLAUCOMA		

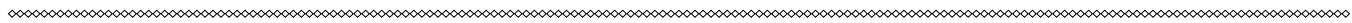
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**PAST PERSONAL MEDICAL HISTORY**

<b>CONDITION</b>	<b>YEAR OF ONSET</b>	<b>ADDITIONAL COMMENTS</b>
VISUAL LOSS		
DIABETIC RETINOPATHY		
MACULAR DEGENERATION		
COLOR BLIND		
HEARING LOSS		
CHRONIC HEADACHES / MIGRAINES		
SEIZURE DISORDER		
FAINTING SPELLS		
LOSS OF CONSCIOUSNESS		
OBESITY		
EATING DISORDER		
ENVIRONMENTAL ALLERGIES		
DENTAL PROBLEMS		
NECK PROBLEMS		
THYROID DISEASE		
HIATAL HERNIA		
REFLUX DISEASE (GERD)		
PEPTIC ULCER		
BLEEDING ULCER		
H. PYLORI		
GASTRITIS		
IBS		
CHRONIC DIARRHEA		
CHRONIC CONSTIPATION		
DIVERTICULOSIS / DIVERTICULITIS		
CROHN'S / COLITIS / ILEITIS		

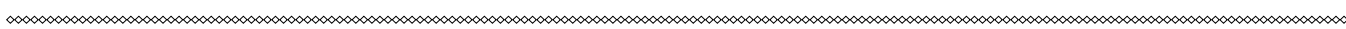


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**PAST PERSONAL MEDICAL HISTORY**

<b>CONDITION</b>	<b>YEAR OF ONSET</b>	<b>ADDITIONAL COMMENTS</b>
HEMORRHOIDS		
ABNORMAL LIVER FUNCTION		
HEPATITIS		
CIRRHOSIS		
GALLBLADDER DISEASE		
PANCREATITIS		
ARTHRITIS		
DISC DISEASE		
FRACTURES		
SPINAL STENOSIS		
OSTEOPOROSIS		
OSTEOARTHRITIS		
MOTOR VEHICLE ACCIDENT		
WORK ACCIDENT		
SEAT BELT USE ____% OF TIME		
ANEMIA		
LYMPHOMA		
WHITE BLOOD CELL DISORDER		
IMPAIRED IMMUNITY		
ABN. BLEEDING TENDENCIES		
COUMADIN USE		
ABN. KIDNEY FUNCTION		
KIDNEY STONES		
KIDNEY / BLADDER INFECTIONS		
INCONTINENCE		
SKIN CANCER		



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**PAST PERSONAL MEDICAL HISTORY**

<b>CONDITION</b>	<b>YEAR OF ONSET</b>	<b>ADDITIONAL COMMENTS</b>
ECZEMA		
PSORIASIS		
SEBORRHEA		
HAIR / NAIL DISORDERS		
SEXUAL DYSFUNCTION		
INFERTILITY		
POSITIVE TB TEST		
HERPES		
HISTORY OF STDs		
LYME DISEASE		
CHRONIC FATIGUE SYNDROME		
HIV		
MEMORY DISTURBANCES		
PARKINSON'S DISEASE		
NEUROPATHY		
MULTIPLE SCLEROSIS		
TREMORS		
BALANCE PROBLEMS		
MUSCLE SPASMS		
RESTLESS LEG SYNDROME		
TENDONITIS		
POLYMYALGIA		
GOUT		
ANY PROSTHETIC DEVICES		
INSOMNIA		
SLEEP DISORDER		



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**PAST PERSONAL MEDICAL HISTORY**

<b>CONDITION</b>	<b>YEAR OF ONSET</b>	<b>ADDITIONAL COMMENTS</b>
SLEEP APNEA		
HISTORY OF RADIATION		
LEARNING DISABILITY		
DYSLEXIA		
ADD / ADHD		
ANXIETY		
DEPRESSION		
PHOBIAS		
MANIC DEPRESSION		
BIPOLAR DISORDER		
OCD		
ADJUSTMENT REACTIONS		
SUICIDE ATTEMPTS		
HISTORY OF PHYSICAL ABUSE		
HISTORY OF EMOTIONAL ABUSE		
PAST OR PRESENT ADDICTIONS TYPE: _____		

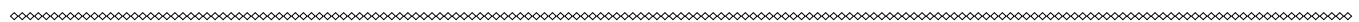
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**PAST PERSONAL SURGICAL HISTORY**

SURGERY TYPE	YEAR	ADDITIONAL COMMENTS
BRAIN		
EYES - CATARACTS		
SINUS / NASAL / EAR		
TONSILS / NECK		
BREAST-BIOPSY / LUMPECTOMY / MASTECTOMY		
HEART-BYPASS / BALLOON ANGIOPLASTY / STENTS / VALVES		
LUNG / CHEST		
ABDOMINAL-HERNIA REPAIR / APPENDECTOMY / GALLBLADDER / STOMACH / BOWEL / HEMORRHOIDS		
NUMBER OF CHILDBIRTHS _____		
NUMBER OF PREGNANCIES _____		
HYSTERECTOMY / REMOVAL OF OVARIES / TUBAL LIGATION		
KIDNEY / KIDNEY STONES / BLADDER		
PROSTATE / VASECTOMY		
HIP / KNEE / JOINT REPLACEMENT		
BACK / DISC		
COSMETIC		
CARPAL TUNNEL		
ANEURYSM REPAIR		
VARICOSE VEINS		
SKIN		
OTHER: _____		
OTHER: _____		

PLEASE NOTE: IF, WHILE COMPLETING THIS QUESTIONNAIRE, YOU COME ACROSS ANY HIGHLY SENSITIVE ISSUES THAT YOU FIND DIFFICULT TO WRITE ABOUT BUT YOU WOULD STILL LIKE TO DISCUSS, JUST INDICATE THE ISSUE WITH AN (\*) ASTERISK AND WE WILL TALK ABOUT IT DURING YOUR EXAMINATION.



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**REVIEW OF SYMPTOMS**

PLEASE CHECK ANY SYMPTOMS YOU ARE EXPERIENCING:

**GENERAL:**

- WEIGHT LOSS\_\_
- WEIGHT GAIN\_\_
- NIGHT SWEATS\_\_
- INSOMNIA\_\_
- FATIGUE\_\_

**CARDIOVASCULAR:**

- CHEST PAIN\_\_
- PALPITATIONS\_\_
- ANKLE SWELLING\_\_
- CALF PAIN\_\_
- VARICOSE VEINS\_\_

**RESPIRATORY:**

- COUGH\_\_
- COUGHING BLOOD\_\_
- SPUTUM PRODUCTION\_\_
- WHEEZING\_\_
- SHORTNESS OF BREATH\_\_

**ENT:**

- DEAFNESS\_\_
- NOSE BLEEDS\_\_
- RUNNY NOSE\_\_
- SNEEZING\_\_
- HOARSENESS\_\_
- SORE THROAT\_\_

**ENDOCRINE:**

- EXCESSIVE THIRST\_\_
- EXCESSIVE HAIR\_\_
- HAIR LOSS\_\_
- HOT FLASHES\_\_
- ALWAYS HOT\_\_
- ALWAYS COLD\_\_
- ERECTILE DYSFUNCTION\_\_
- INFERTILITY\_\_
- DECREASED LIBIDO\_\_
- PAIN DURING INTERCOURSE\_\_

**GASTROINTESTINAL:**

- DIFFICULTY SWALLOWING\_\_
- HEART BURN\_\_
- NAUSEA\_\_
- VOMITING\_\_
- DIARRHEA\_\_
- CONSTIPATION\_\_
- BLOOD IN STOOLS\_\_
- BLACK STOOLS\_\_
- ABDOMINAL PAIN\_\_
- JAUNDICE\_\_

**NEUROLOGICAL:**

- DOUBLE VISION\_\_
- HEADACHE\_\_
- DIZZINESS\_\_
- FAINING\_\_
- WEAKNESS\_\_
- NUMBNESS\_\_
- TINGLING\_\_
- RINGING IN EAR\_\_
- TREMORS\_\_

**EYES:**

- BLURRY VISION\_\_
- FLASHING LIGHTS\_\_
- ITCHY EYES\_\_

**DERMATOLOGIC:**

- SUSPICIOUS MOLES\_\_
- SKIN RASHES\_\_
- SKIN ULCERS\_\_
- ACNE\_\_

**GYNECOLOGICAL:**

- MENOPAUSE\_\_
- IRREGULAR PERIODS\_\_
- BREAST TENDERNESS\_\_
- BREAST LUMPS\_\_
- VAGINAL IRRITATION\_\_
- VAGINAL DISCHARGE\_\_
- VAGINAL DRYNESS\_\_

**UROLOGICAL:**

- PAINFUL URINATION\_\_
- RECURRENT INFECTIONS\_\_
- FREQUENT URINE\_\_
- BLOOD IN URINE\_\_
- INCONTINENCE\_\_
- INCOMPLETE BLADDER\_\_
- EMPTYING\_\_
- DRIBBLING\_\_
- SLOW URINE FLOW\_\_

**PSYCHOLOGICAL:**

- DEPRESSION\_\_
- ANXIETY\_\_
- MEMORY LOSS\_\_
- HALLUCINATIONS\_\_
- SUICIDAL THOUGHTS\_\_
- FREQUENT MOOD\_\_
- CHANGES\_\_

**ORTHOPEDIC:**

- JOINT PAIN\_\_
- JOINT SWELLING\_\_
- BACKACHE\_\_
- KNEE PAIN\_\_
- OTHER\_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

**PLEASE LIST YOUR 5 PERSONAL HEALTH GOALS:**

- 1 \_\_\_\_\_
- 2 \_\_\_\_\_
- 3 \_\_\_\_\_
- 4 \_\_\_\_\_
- 5 \_\_\_\_\_



PETRA TRAVNICEK, MD, FACP



**FAMILY HISTORY: GENETIC & ACQUIRED PREDISPOSITIONS**

<b>DISEASE</b>	<b>RELATIVE</b>	<b>LIVING</b>	<b>AGE AT DEATH</b>
HEART DISEASE	MOTHER		
	FATHER		
	SISTER		
	BROTHER		
	CHILD		
CANCER	MOTHER		
	FATHER		
	SISTER		
	BROTHER		
	CHILD		
DIABETES	MOTHER		
	FATHER		
	SISTER		
	BROTHER		
	CHILD		
HYPERTENSION	MOTHER		
	FATHER		
	SISTER		
	BROTHER		
	CHILD		
HIGH CHOLESTEROL	MOTHER		
	FATHER		
	SISTER		
	BROTHER		
	CHILD		

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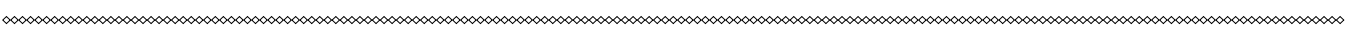
**ADULT IMMUNIZATION HISTORY**

IMMUNIZATION	DATE RECEIVED	NEVER RECEIVED	WOULD LIKE TO RECEIVE
HEPATITIS A			
HEPATITIS B			
TETANUS / DIPHTHERIA			
INFLUENZA			
PNEUMOCOCCAL			
MENINGOCOCCAL			
CHICKEN POX / SHINGLES			
PPD / TB TEST			
OTHER: _____			
OTHER: _____			

**DO YOU HAVE ANY FOOD OR DRUG ALLERGIES?**

ALLERGY	REACTION	ALLERGY	REACTION
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

ALCOHOL CONSUMPTION: HOW MANY DAYS A WEEK? \_\_\_\_\_ HOW MANY OUNCES? \_\_\_\_\_  
 DOES IT INTERFERE WITH WORK, SCHOOL, RELATIONSHIPS? \_\_\_\_\_  
 HAVE YOU EVER RECEIVED TREATMENT? \_\_\_\_\_ TYPE: \_\_\_\_\_ RELAPSES: \_\_\_\_\_  
 HISTORY OF TOBACCO USE: NEVER USED TOBACCO (YES \_\_\_\_\_ NO \_\_\_\_\_)  
 PRESENT USE? (YES \_\_\_\_\_ NO \_\_\_\_\_) TYPE AND AMOUNT \_\_\_\_\_  
 \*IF YOU HAVE EVER SMOKED CIGARETTES, PLEASE DO THE CALCULATION;  
 # OF PACKS PER DAY \_\_\_\_\_ X # OF YEARS SMOKED \_\_\_\_\_ = \_\_\_\_\_ PACK YEARS  
 QUIT DATE \_\_\_\_\_ WHAT EFFORTS HAVE YOU USED TO STOP \_\_\_\_\_  
 ARE YOU INTERESTED IN STOPPING? (YES \_\_\_\_\_ NO \_\_\_\_\_)  
 CAFFEINE INTAKE: # OF CUPS OF COFFEE/DAY \_\_\_\_\_ # OF CUPS OF TEA/DAY \_\_\_\_\_  
 # OF 8OZ SERVINGS OF COLA BEVERAGE/DAY \_\_\_\_\_  
 PLEASE DESCRIBE ANY "AT RISK" BEHAVIORS, SUCH AS CAR RACING, MOUNTAIN CLIMBING, GLIDING, ETC.  
 OR OTHER DANGEROUS WORK OR LEISURE PURSUITS OR "AT RISK" SEXUAL PRACTICES:



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**NUTRITION SURVEY**

HOW WOULD YOU RATE YOUR DIET IN GENERAL? (PLEASE CHECK ONE)

VERY HEALTHY\_\_\_ HEALTHY\_\_\_ MODERATELY HEALTHY\_\_\_ POOR\_\_\_ VERY POOR\_\_\_

ON AVERAGE, WHAT IS THE TOTAL NUMBER OF SERVINGS OF FRUITS AND VEGETABLES THAT YOU HAVE EACH DAY? \_\_\_\_\_

DO YOU HAVE FOOD ALLERGIES OR INTOLERANCES?

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

PLEASE DESCRIBE THE HEALTHY AND UNHEALTHY ASPECTS OF YOUR DIET:

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

PLEASE LIST ANY IMPROVEMENTS WOULD LIKE TO MAKE:

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

WOULD YOU LIKE MORE INFORMATION ABOUT NUTRITION? YES\_\_\_ OR NO\_\_\_  
IF YES, WHAT KIND & HOW CAN WE HELP YOU?

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

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**USE OF COMPLIMENTARY ALTERNATIVE MEDICINE**

THERAPY	HAVE USED	CONSIDERED USING
ACUPUNCTURE		
HOMEOPATHY		
NATUROPATHY		
MAGNETIC THERAPY		
HERBAL REMEDIES		
MANUAL HEALING:		
CHIROPRACTIC / MASSAGE		
THERAPEUTIC TOUCH		
MIND & BODY INTERVENTIONS: MEDITATION / GUIDED IMAGING HYPNOSIS / BIOFEEDBACK / PRAYER		
CHELATION THERAPY		
AROMA THERAPY		
OTHER - PLEASE DESCRIBE: _____		

**ACCIDENT PREVENTION & AUTO SAFETY ANSWER, OR CHECK YES OR NO**

DO YOU USE PROTECTIVE SAFETY EQUIPMENT WHEN EXERCISING, PERFORMING WORK DUTIES OR OTHER PHYSICAL ACTIVITIES? ___Y ___N	_____ % OF TIME PROTECTIVE EQUIPMENT USED
# AUTO MILES PER YEAR _____	PERCENTAGE OF TIME WEARING SEATBELT _____ %
DO YOU HAVE A TENDENCY TO SPEED? ___Y ___N	DO YOU HAVE A VISUAL PROBLEM? ___Y ___N
DO YOU CHANGE LANES OFTEN? ___Y ___N	DO YOU HAVE A HEARING PROBLEM? ___Y ___N
ARE YOU DISTRACTED BY MUSIC OR CONVERSATION? ___Y ___N	MOVEMENT / COORDINATION PROBLEM? ___Y ___N
DO YOU USE YOUR CELL PHONE WHILE DRIVING? ___Y ___N	TAKE MEDICATION THAT MAY MAKE YOU TOO SLEEPY OR IMPAIR YOUR DRIVING? ___Y ___N
DO YOU FEEL THAT YOUR VEHICLE IS STURDY IF IN A COLLISION? ___Y ___N	# TIMES IN THE PAST 10 YEARS YOU AS A VEHICLE DRIVER WERE DRUG OR ALCOHOL IMPAIRED? _____
# TIMES IN THE PAST 10 YEARS HAVE YOU AS A VEHICLE DRIVER FALLEN ASLEEP, OR WERE TOO TIRED TO DRIVE SAFELY? _____	HOW MANY PEOPLE DO YOU THINK ARE KILLED IN MOTOR VEHICLE ACCIDENTS IN THE USA YEARLY? _____



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**EXERCISE HABITS**

PLEASE DESCRIBE YOUR EXERCISE

TYPE: \_\_\_\_\_

FREQUENCY: \_\_\_\_\_

OTHER TYPES OF PHYSICAL ACTIVITY:

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

GOALS FOR EXERCISE THIS YEAR:

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

HOW WILL YOU ACHIEVE THESE GOALS?

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

**SLEEP**

PLEASE CHECK THE CONDITION WHICH DESCRIBES HOW YOUR SLEEP IS OR HOW IT HAS CHANGED THIS YEAR:

- \_\_\_\_\_ I HAVE NO SLEEP PROBLEMS
- \_\_\_\_\_ DIFFICULTY STAYING ASLEEP
- \_\_\_\_\_ SLEEP APNEA
- \_\_\_\_\_ AWAKEN FREQUENTLY DURING THE NIGHT
- \_\_\_\_\_ SLEEP TOO MUCH
- \_\_\_\_\_ NOT ENOUGH
- \_\_\_\_\_ DIFFICULTY GETTING UP
- \_\_\_\_\_ EARLY MORNING AWAKENINGS
- \_\_\_\_\_ SLEEPY DURING THE DAY
- \_\_\_\_\_ DIFFICULTY FALLING ASLEEP
- \_\_\_\_\_ PROBLEMS WITH SNORING
- \_\_\_\_\_ SLEEP WALKING

**SOCIAL HISTORY**

ANY CHANGES IN MARITAL STATUS? \_\_\_\_\_

CHANGES IN WORK? \_\_\_\_\_

NEW CHILDREN OR GRANDCHILDREN? \_\_\_\_\_

NEW HOBBIES? \_\_\_\_\_

COMPLETED BY \_\_\_\_\_

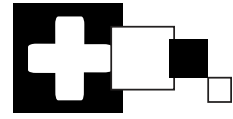
SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

(PRINT THEN SIGN DOCUMENT)

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**CONCIERGE MEDICAL**  
SERVICES

DR PRICE & DR TRAVNICEK

**THE BURNS DEPRESSION INVENTORY**

<b>INSTRUCTIONS:</b> THE FOLLOWING IS A LIST OF SYMPTOMS THAT PEOPLE SOMETIMES HAVE. CHECK THE BOX THAT BEST DESCRIBES HOW MUCH THAT SYMPTOM OR PROBLEM HAS BOTHERED YOU DURING THE PAST WEEK.		<b>0 - NOT AT ALL</b>	<b>1 - SOMEWHAT</b>	<b>2 - MODERATE</b>	<b>3 - A LOT</b>						
<b>SYMPTOM LIST</b>											
<b>1</b>	<b>SADNESS:</b> HAVE YOU BEEN FEELING SAD OR DOWN IN THE DUMPS?										
<b>2</b>	<b>DISCOURAGEMENT:</b> DOES THE FUTURE LOOK HOPELESS?										
<b>3</b>	<b>LOW SELF ESTEEM:</b> DO YOU FEEL WORTHLESS OR THINK OF YOURSELF AS A FAILURE?										
<b>4</b>	<b>INFERIORITY:</b> DO YOU FEEL INADEQUATE OR INFERIOR TO OTHERS?										
<b>5</b>	<b>GUILT:</b> DO YOU GET SELF-CRITICAL AND BLAME YOURSELF FOR EVERYTHING?										
<b>6</b>	<b>INDECISIVENESS:</b> DO YOU HAVE TROUBLE MAKING UP YOUR MIND ABOUT THINGS?										
<b>7</b>	<b>IRRITABILITY &amp; FRUSTRATION:</b> DO YOU FEEL RESENTFUL AND ANGRY A GOOD DEAL OF THE TIME?										
<b>8</b>	<b>LOSS OF INTEREST IN LIFE:</b> HAVE YOU LOST INTEREST IN YOUR CAREER, HOBBIES, FAMILY, OR FRIENDS?										
<b>9</b>	<b>LOSS OF MOTIVATION:</b> DO YOU FEEL OVERWHELMED & HAVE TO PUSH YOURSELF HARD TO DO THINGS?										
<b>10</b>	<b>POOR SELF-IMAGE:</b> DO YOU THINK YOU'RE LOOKING OLD OR UNATTRACTIVE?										
<b>11</b>	<b>APPETITE CHANGES:</b> HAVE YOU LOST YOUR APPETITE, OR DO YOU OVEREAT OR BINGE COMPULSIVELY?										
<b>12</b>	<b>SLEEP CHANGES:</b> DO YOU SUFFER FROM INSOMNIA, FIND IT HARD TO GET A GOOD NIGHT'S SLEEP, OR ARE YOU EXCESSIVELY TIRED & SLEEPING TOO MUCH?										
<b>13</b>	<b>LOSS OF LIBIDO:</b> HAVE YOU LOST YOUR INTEREST IN SEX?										
<b>14</b>	<b>HYPOCHONDRIASIS:</b> DO YOU WORRY A GREAT DEAL ABOUT YOUR HEALTH?										
<b>15</b>	<b>SUICIDAL IMPULSES:</b> DO YOU HAVE THOUGHTS THAT LIFE IS NOT WORTH LIVING OR THAT YOU MIGHT BE BETTER OFF DEAD?										
<b>ADD UP YOUR TOTAL SCORE FOR THE 33 SYMPTOMS &amp; RECORD HERE</b>											
<table border="1"> <tr> <td><b>TOTAL SCORE &amp; DEGREE OF DEPRESSION</b></td> </tr> <tr> <td>0 - 4 = MINIMAL OR NO DEPRESSION</td> </tr> <tr> <td>5 - 10 = BORDERLINE DEPRESSION</td> </tr> <tr> <td>11 - 20 = MILD DEPRESSION</td> </tr> <tr> <td>21 - 30 = MODERATE DEPRESSION</td> </tr> <tr> <td>31 - 45 = SEVERE DEPRESSION</td> </tr> </table>		<b>TOTAL SCORE &amp; DEGREE OF DEPRESSION</b>	0 - 4 = MINIMAL OR NO DEPRESSION	5 - 10 = BORDERLINE DEPRESSION	11 - 20 = MILD DEPRESSION	21 - 30 = MODERATE DEPRESSION	31 - 45 = SEVERE DEPRESSION	<b>DATE</b>			
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**THE FEELING GOOD HANDBOOK**  
DAVID BURNS, M.D. - PENGUIN GROUP, 1999

**THE EPWORTH SLEEPINESS SCALE**

THE EPWORTH SLEEPINESS SCALE IS WIDELY USED IN THE FIELD OF SLEEP MEDICINE AS A SUBJECTIVE MEASURE OF A PATIENT’S SLEEPINESS. THE TEST IS A LIST OF EIGHT SITUATIONS IN WHICH YOU RATE YOUR TENDENCY TO BECOME SLEEPY ON A SCALE 0, NO CHANCE OF DOZING, TO 3, HIGH CHANCE OF DOZING. WHEN YOU FINISH THE TEST, ADD UP THE VALUES OF YOUR RESPONSES. YOUR TOTAL SCORE IS BASED ON A SCALE OF 0 TO 24. THE SCALE ESTIMATES WHETHER YOU ARE EXPERIENCING EXCESSIVE SLEEPINESS THAT POSSIBLY REQUIRES MEDICAL ATTENTION.

**HOW SLEEPY ARE YOU?**

**HOW LIKELY ARE YOU TO DOZE OFF OR FALL ASLEEP IN THE FOLLOWING SITUATIONS?** YOU SHOULD RATE YOUR CHANCES OF DOZING OFF, NOT JUST FEELING TIRED. EVEN IF YOU HAVE NOT DONE SOME OF THESE THINGS RECENTLY, TRY TO DETERMINE HOW THEY WOULD HAVE AFFECTED YOU. FOR EACH SITUATION, DECIDE WHETHER OR NOT YOU WOULD HAVE:

- 0 = NO CHANCE OF DOZING**
- 1 = SLIGHT CHANCE OF DOZING**
- 2 = MODERATE CHANCE OF DOZING**
- 3 = HIGH CHANCE OF DOZING**

WRITE DOWN THE NUMBER CORRESPONDING TO YOUR CHOICE IN THE RIGHT COLUMN, THEN TOTAL YOUR SCORE.

SITUATION	CHANCE OF DOZING
WATCHING TV	
SITTING INACTIVE IN A PUBLIC PLACE (E.G. THEATER OR A MEETING)	
AS A PASSENGER IN A CAR FOR AN HOUR WITHOUT A BREAK	
LYING DOWN TO REST IN THE AFTERNOON	
SITTING AND TALKING TO SOMEONE	
SITTING QUIETLY AFTER LUNCH WITHOUT ALCOHOL	
IN A CAR, WHILE STOPPED FOR A FEW MINUTES IN TRAFFIC	
<b>TOTAL SCORE</b>	

**ANALYZE YOUR SCORE**

**INTERPRETATION:**

- 0-7 = IT IS UNLIKELY THAT YOU ARE ABNORMALLY SLEEPY.
- 8-9 = YOU HAVE AN AVERAGE AMOUNT OF DAYTIME SLEEPINESS.
- 10-15 = YOU MAY BE EXCESSIVELY SLEEPY DEPENDING ON THE SITUATION. CONSIDER SEEKING MEDICAL ATTENTION.
- 16-24 = YOU ARE EXCESSIVELY SLEEPY AND SHOULD CONSIDER SEEKING MEDICAL ATTENTION.

REFERENCE: JOHNS MW. A NEW METHOD FOR MEASURING DAYTIME SLEEPINESS: THE EPWORTH SLEEPINESS SCALE. SLEEP 1991; 14(6):540-5.

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