SOUTHWEST PULMONARY ASSOCIATES

PATIENT INFORMATION

Patient's Name	SS#	Birth Date	Sex M F
Street Address	City	State	Zip Code
Patient's Email	Home Phone#	Cell Phone#	
Race/Ethnicity	Preferred Method of Contact Phone Email	Primary Spoken Language	
Emergency Notification	Relationship	Phone#	
Primary Care Physician		Primary Physician's Phone#	
Referring Physician		Referring Physician's Phone#	

RESPONSIBLE PARTY

Name	Relationship
Address	S.S#

INSURANCE INFORMATION

Primary Insurance Carrier	Policy or Subscriber ID#
Name of Policy Holder	Relationship to Patient
Policy Holder's Social Security #	Policy Holder's Date of Birth
Secondary Insurance Carrier	Policy or Subscriber ID#
Name of Policy Holder	Relationship to Patient
Policy Holder's Social Security #	Policy Holder's Date of Birth

Patient Agreement and Consent:
My signature below indicates my consent for treatment of/as patient and responsibility for paying for services rendered. Forms for Authorization to use Protected Health Information are attached and will be reviewed and completed.

Patient's Signature_____ Date_____

SOUTHWEST PULMONARY ASSOCIATES

GENERAL CONSENT FORM

Patient Name: _____ Date of Birth: _____/_____/_____

Assignment of Benefits. I authorize SWP Physician services, (Southwest Pulmonary Associates) to submit claims on my behalf directly to Medicare/Medicaid/my private health insurance carrier. This means that SWP will collect payment for supplies and services provided. I understand that I am financially responsible to the provider(s) for the charges not paid or payable. I authorize you to release any information necessary to insurance carriers regarding illnesses and treatment to process claims. This assignment will remain in effect until revoked by me in writing.

Patient Initials: _____

Consent for Treatment. I consent for SWP to administer treatments, tests and/or diagnostic tests to treat my/the patient's injury/illness on an outpatient basis. I acknowledge there is no guarantee as to the outcome of any treatment I/the patient receives. In compliance with state law, if another individual is accidently exposed to my/the patient's blood or bodily fluids (BBF); or if a medical or surgical procedure could expose another individual to my/the patient's BBF, SWP may have such BBF tested for human immunodeficiency infection (HIV/AIDS) at SWP's expense.

Patient Initials: _____

Electronic Prescription. I understand SWP utilizes electronic prescribing technology and participates with SureScripts. SureScripts operates the Pharmacy Health Information Exchange, which facilitates the electronic transmission of prescription information between providers and pharmacists. SureScripts also provides prescription data on any medications, known as medication history, which are prescribed to me/the patient.

Involvement of Others in Care. I authorize SWP to discuss my/the patient's care and medical needs with the following persons:

Name	Date of Birth	Relationship	Phone

Phone calls. By providing contact information, I authorize SWP, its assignees, and third party collection agents to use the contact information I have provided to communicate with me and to place calls to my home/cellular/employment telephone; leave voice or text messages; and use pre-recorded/artificial/voice messages and/or auto-dialing devices in connection with any communication to me.

May We Contact You by Phone and Leave a Message About Your Care?

Primary Phone #: _____ Secondary Phone #: _____

- ☐ Leave a message with contact number only.
- ☐ Leave message with detailed information.
- ☐ Do not leave message.

- ☐ Leave message with contact number only.
- ☐ Leave message with detailed information.
- ☐ Do not leave message.

Patient Financial Policy
I acknowledge receipt of the "Patient Financial Policy." **Patient Initials: _____**

Notice of Privacy Practices
I acknowledge receipt of the "Notice of Privacy practices." **Patient Initials: _____**

Minor Patient Photograph (when applicable)
I consent for SWP to photograph the minor patient for identification purposes only. **Patient Initials: _____**

_____
Print name of Patient or Personal Representative

_____ _____
Signature of Patient or Personal Representative Date

Southwest Pulmonary Associates, L.L.P.
Acknowledgement of Receipt of Notice of Privacy Practices

Patient Name: ____ **Patient ID #:** __________________________

I hereby acknowledge that I have received a copy of Southwest Pulmonary Associates, L.L.P.'s Notice of Privacy Practices. I understand that I have the right to refuse to sign this acknowledgement if I so choose.

____ _________________________

Signature of Patient or Legal Representative **Date**

____

Printed Name of Patient's Representative (*if applicable*)

Relationship to Patient (*if applicable*)

- ☐ Parent or guardian of unemancipated minor
- ☐ Court appointed guardian
- ☐ Executor or administrator of decedent's estate
- ☐ Power of Attorney

- -

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices on the following date,

______________________________ but acknowledgment could not be obtained because:

- ☐ Patient/representative refused to sign
- ☐ Emergency situation prevented us from obtaining acknowledgement at this time (will attempt again at a later date)
- ☐ Communication barriers prohibited obtaining acknowledgement (Explain)

____

____

____

- ☐ Other (Specify)

____

____

SOUTHWEST PULMONARY ASSOCIATES

Notice of No Show Acknowledgement

If you are unable to keep your appointment, you are required to provide a 24-hour notice of cancellation.

Failure to cancel your appointment with a 24-hour notice will result in a phone call to the number on file and a "NO SHOW" warning letter mailed to the address on file.

To assist you in keeping your appointment, you will receive a reminder call two days prior to your appointment. Please confirm with our staff that we have your most current phone number on file.

If there is a subsequent "NO SHOW" appointment, your account may be charged **$35.00** for which you are entirely financially responsible. It is not covered by your insurance and will not be billed to insurance. You will need to pay the "NO SHOW" fee in full to obtain any further appointments with our office. Three “No Show” occurrences in a 1-year period, may result in termination from the practice.

We hope that all of our patients get the care they need and show consideration by notifying us in advance of the inability to keep an appointment so that another patient may have that time slot.

We are very concerned when you miss appointments that you are not receiving the necessary medical care required for your injury or illness.
Please call if you are experiencing any problems. We value you as a patient.

_____

Patient printed name Date

_____

Signature of patient/guardian

Southwest Pulmonary Associates, L.L.P.
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.

UNDERSTANDING YOUR HEALTH RECORD/INFORMATION

Each time you visit a hospital, physician, dentist, or other healthcare provider, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. This information often referred to as your health or medical record, serves as a basis for planning your care and treatment and serves as a means of communication among the many health professionals who contribute to your care. Understanding what is in your record and how your health information is used helps you to ensure its accuracy, better understand who, what, when, where, and why others may access your health information, and helps you make more informed decisions when authorizing disclosure to others.

YOUR HEALTH INFORMATION RIGHTS

Unless otherwise required by law, your health record is the physical property of the healthcare practitioner or facility that compiled it. However, you have certain rights with respect to the information. You have the right to:

1. **Receive a copy of this Notice of Privacy Practices** from us upon enrollment or upon request.
2. **Request restrictions on our uses and disclosures of your protected health information** for treatment, payment and health care operations. This includes your right to request that we not disclose your health information to a health plan for payment or health care operations if you have paid in full and out of pocket for the services provided. We reserve the right not to agree to a given requested restriction.
3. **Request to receive communications of protected health information in confidence.**
4. **Inspect and obtain a copy of the protected health information** contained in your medical and billing records and in any other Practice records used by us to make decisions about you. If we maintain or use electronic health records, you will also have the right to obtain a copy or forward a copy of your electronic health record to a third party. A reasonable copying/labor charge may apply.
5. **Request an amendment to your protected health information**. However, we may deny your request for an amendment, if we determine that the protected health information or record that is the subject of the request:
   - was not created by us, unless you provide a reasonable basis to believe that the originator of the protected health information is no longer available to act on the requested amendment;
   - is not part of your medical or billing records;
   - is not available for inspection as set forth above; or
   - is accurate and complete.

   In any event, any agreed upon amendment will be included as an addition to, and not a replacement of, already existing records.
6. **Receive an accounting of disclosures of protected health information** made by us to individuals or entities other than to you, except for disclosures:
   - to carry out treatment, payment and health care operations as provided above;
   - to persons involved in your care or for other notification purposes as provided by law;
   - to correctional institutions or law enforcement officials as provided by law;
   - for national security or intelligence purposes;
   - that occurred prior to the date of compliance with privacy standards (April 14, 2003);
   - incidental to other permissible uses or disclosures;
   - that are part of a limited data set (does not contain protected health information that directly identifies individuals);
   - made to patient or their personal representatives;
   - for which a written authorization form from the patient has been received
7. **Revoke your authorization to use or disclose health information** except to the extent that we have already been taken action in reliance on your authorization, or if the authorization was obtained as a condition of obtaining insurance coverage and other applicable law provides the insurer that obtained the authorization with the right to contest a claim under the policy.
8. **Receive notification if affected by a breach of unsecured PHI**

SOUTHWEST PULMONARY ASSOCIATES

HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED

This organization may use and/or disclose your medical information for the following purposes:

Treatment: We may use and disclose protected health information in the provision, coordination, or management of your health care, including consultations between health care providers regarding your care and referrals for health care from one health care provider to another.

Payment: We may use and disclose protected health information to obtain reimbursement for the health care provided to you, including determinations of eligibility and coverage and other utilization review activities.

Regular Healthcare Operations: We may use and disclose protected health information to support functions of our practice related to treatment and payment, such as quality assurance activities, case management, receiving and responding to patient complaints, physician reviews, compliance programs, audits, business planning, development, management and administrative activities.

Appointment Reminders: We may use and disclose protected health information to contact you to provide appointment reminders.

Treatment Alternatives: We may use and disclose protected health information to tell you about or recommend possible treatment alternatives or other health related benefits and services that may be of interest to you

Health-Related Benefits and Services: We may use and disclose protected health information to tell you about health-related benefits, services, or medical education classes that may be of interest to you.

Individuals Involved in Your Care or Payment for Your Care: Unless you object, we may disclose your protected health information to your family or friends or any other individual identified by you when they are involved in your care or the payment for your care. We will only disclose the protected health information directly relevant to their involvement in your care or payment. We may also disclose your protected health information to notify a person responsible for your care (or to identify such person) of your location, general condition or death.

Business Associates: There may be some services provided in our organization through contracts with Business Associates. Examples include physician services in the emergency department and radiology, certain laboratory tests, and a copy service we use when making copies of your health record. When these services are contracted, we may disclose some or all of your health information to our Business Associate so that they can perform the job we have asked them to do. To protect your health information, however, we require the Business Associate to appropriately safeguard your information.

Organ and Tissue Donation: If you are an organ donor, we may release medical information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

Worker's Compensation: We may release protected health information about you for programs that provide benefits for work related injuries or illness.

Communicable Diseases: We may disclose protected health information to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition.
Health Oversight Activities: We may disclose protected health information to federal or state agencies that oversee our activities.

Law Enforcement: We may disclose protected health information as required by law or in response to a valid judge ordered subpoena. For example in cases of victims of abuse or domestic violence; to identify or locate a suspect, fugitive, material witness, or missing person; related to judicial or administrative proceedings; or related to other law enforcement purposes.

Military and Veterans: If you are a member of the armed forces, we may release protected health information about you as required by military command authorities.

Lawsuits and Disputes: We may disclose protected health information about you in response to a court or administrative order. We may also disclose medical information about you in response to a subpoena, discovery request, or other lawful process.

Inmates: If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release protected health information about you to the correctional institution or law enforcement official. An inmate does not have the right to the Notice of Privacy Practices.

Abuse or Neglect: We may disclose protected health information to notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

Coroners, Medical Examiners, and Funeral Directors: We may release protected health information to a coroner or medical examiner. This may be necessary to identify a deceased person or determine the cause of death. We may also release protected health information about patients to funeral directors as necessary to carry out their duties.

Public Health Risks: We may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. The disclosure will be made for the purpose such as controlling disease, injury or disability.

Serious Threats: As permitted by applicable law and standards of ethical conduct, we may use and disclose protected health information if we, in good faith, believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public.

Food and Drug Administration (FDA): As required by law, we may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.

OUR RESPONSIBILITIES

We are required to maintain the privacy of your health information. In addition, we are required to provide you with a notice of our legal duties and privacy practices with respect to information we collect and maintain about you. We must abide by the terms of this notice. We reserve the right to change our practices and to make the new provisions effective for all the protected health information we maintain. If our information practices change, a revised notice will be mailed to the address you have supplied upon request. If we maintain a Web site that provides information about our patient/customer services or benefits, the new notice will be posted on that Web site.

Your health information will not be used or disclosed without your written authorization, except as described in this notice. The following uses and disclosures will be made only with explicit authorization from you: (i) uses and disclosures of your health information for marketing purposes, including subsidized treatment communications; (ii) disclosures that constitute a sale of your health information; and (iii) other uses and disclosures not described in the notice. Except as noted above, you may revoke your authorization in writing at any time.

FOR MORE INFORMATION OR TO REPORT A PROBLEM

If you have questions about this notice or would like additional information, you may contact our Privacy Officer, Katie Brown, at the telephone or address below. If you believe that your privacy rights have been violated, you have the right to file a complaint with the Privacy Officer at Southwest Pulmonary Associates, L.L.P. or with the Secretary of the Department of Health and Human Services. The complaint must be in writing, describe the acts or omissions that you believe violate your privacy rights, and be filed within 180 days of when you knew or should have known that the act or omission occurred. We will take no retaliatory action against you if you make such complaints.

The contact information for both is included below.

U.S. Department of Health and Human Services
Office of the Secretary
200 Independence Avenue, S.W.
Washington, D.C. 20201
Tel: (202) 619-0257
Toll Free: 1-877-696-6775
http://www.hhs.gov/contacts

Southwest Pulmonary Associates, L.L.P.
Katie Brown, Privacy Officer
10100 N. Central Expy. Suite 560
Dallas, TX 75231
Tel: 469-916-0087
Fax: 469-916-0089

NOTICE OF PRIVACY PRACTICES AVAILABILITY

This notice will be prominently posted in the office where registration occurs. You will be provided a hard copy, at the time we first deliver services to you. Thereafter, you may obtain a copy upon request, and the notice will be maintained on the organization's Web site (if applicable Web site exists) for downloading.

SOUTHWEST PULMONARY ASSOCIATES

Patient Name: _____ **Date of Birth:** _____/_____/_____

In order to promote continuity of your medical care, it is important that we keep all physicians that currently treat you, informed of your plan of care with us. Please provide the name and contact information of any other physicians that you currently see. Thank you!

PCP /GP/ Internal Med:

Name: _____ City / Phone Number: _____

Allergist / ENT:

Name: _____ City / Phone Number: _____

Cardiologist:

Name: _____ City / Phone Number: _____

Gastroenterologist (GI):

Name: _____ City / Phone Number: _____

Oncologist:

Name: _____ City / Phone Number: _____

Pulmonologist (prior to SWP):

Name: _____ City / Phone Number: _____

Other:

Name: _____ City / Phone Number: _____

SOUTHWEST PULMONARY ASSOCIATES

PATIENT HEALTH HISTORY

Patient Name: _____ Date of Birth: _____ /_____ /_____

Local Pharmacy: _____ Phone#_____

Mail Order Pharmacy_____ Phone#_____

Please respond to the following questions to the best of your ability. This will help your doctor know more about you. These responses are confidential.

Please list the reason(s) for your visit to our office today: (**Medical Complaints**):

_____

_____

Medical History:

Medical Problem	Year Diagnosed
1.) _____	_____
2.) _____	_____
3.) _____	_____
4.) _____	_____
5.) _____	_____
6.) _____	_____
7,) _____	_____
8.) _____	_____

Do you have any physical limitations? Yes / No Explain _____

_____

SOUTHWEST PULMONARY ASSOCIATES

Patient Name: _____ **Date of Birth:** _____/_____/_____

Medications:

Please list all medications (*prescription and non-prescription*), including vitamins, aspirin, herbs and/or appetite suppressants.

	Name	**Dose/Strength**	**Frequency**
	Example: Lasix	*40 mg.*	*2 in am, 1 in pm*
1.)			
2.)			
3.)			
4.)			
5.)			
6.)			
7.)			
8.)			
9.)			
10.)			
11.)			
12.)			

Allergies:

Please list all medications to which you have an allergy or an adverse response and the corresponding reaction (i.e., Penicillin-arm rash).

	Medication	**Reaction**
1.)		
2.)		
3.)		
4.)		
5.)		

SOUTHWEST PULMONARY ASSOCIATES

Patient Name: _____ **Date of Birth:** _____/_____/_____

Vaccinations:

Have you ever been vaccinated with…?

Yes	No		Date
☐ Yes	☐ No	Influenza	_____
☐ Yes	☐ No	Pneumovax	_____
☐ Yes	☐ No	Prevnar-13	_____
☐ Yes	☐ No	Tuberculosis	_____

Family Medical History:

Please indicate all those immediate family members with the following conditions and the age at which they were first diagnosed.

Example: *Father*
1.) Cancer *45*

	Father	Mother	Sibling 1	Sibling 2	Sibling 3	Sibling 4	Children
1.) Asthma	_____	_____	_____	_____	_____	_____	_____
2.) TB	_____	_____	_____	_____	_____	_____	_____
3.) Emphysema/ COPD	_____	_____	_____	_____	_____	_____	_____
4.) Cardiovascular Disease	_____	_____	_____	_____	_____	_____	_____
5.) Lung Cancer	_____	_____	_____	_____	_____	_____	_____

Father's age _____ or age at death _____ cause_____

Mother's age _____ or age at death _____ cause _____

Siblings (brothers or sisters):

1.) _____ age at death _____ cause_____
2.) _____ age at death _____ cause _____
3.) _____ age at death _____ cause _____
4.) _____ age at death _____ cause _____
5.) _____ age at death _____ cause _____

SOUTHWEST PULMONARY ASSOCIATES

Patient Name: _____ **Date of Birth:** _____/_____/_____

Social History:

Do you smoke? (Cigarettes and/or smokeless tobacco) ☐ Never ☐ No, but used to ☐ Yes

If you used to smoke, when did you quit? _____

How many packs of cigarettes did/do you smoke and for how many years (*i.e., 1 pack/day for 20 years*)?

_____

Do you drink alcohol? ☐ Never ☐ No, but used to ☐ Yes

If you used to drink, when did you quit? _____

How much did/do you drink in an average week? _____ glasses of wine, _____ beers, _____ drinks

Marital status (circle one): married separated divorced widowed single

Number of children: _____ with whom do you live? _____

Do you have any pets/what type? _____

Are you retired? ☐ Yes ☐ No Previous (or current) occupation: _____

How do you spend your leisure time/hobbies? _____

Do you consume caffeine?: ☐ Never ☐ No, but used to ☐ Yes

If you used to consume caffeine, when did you quit? _____

If yes, how much in an average day? _____ sodas, _____ cups of coffee, _____ glasses of tea

Do you take illicit drugs or abuse prescription medications? ☐ Never ☐ No, but used to ☐ Yes

If yes, please specify: _____

Do you exercise?: ☐ Yes ☐ No

If yes, describe how and how often _____

Chemical/Environmental Exposures: *(check all that apply)*

☐ Coal Dust ☐ Silica Dust ☐ Paint Sprays ☐ Chemical Fumes ☐ Asbestos ☐ Caged Birds

☐ Other _____

SOUTHWEST PULMONARY ASSOCIATES

Patient Name: _____ **Date of Birth:** _____/_____/_____

Surgical History:

Have you had any surgeries/operations in the past? ☐ Yes ☐ No
If yes, please list type and the approximate year.

	Surgery	Year
1.)	_____	_____
2.)	_____	_____
3.)	_____	_____
4.)	_____	_____
5.)	_____	_____
6.)	_____	_____
7.)	_____	_____

Have you ever been hospitalized for any reason besides surgery? ☐ Yes ☐ No

If yes, reason and dates:

_____

_____

_____

_____

Have you ever had a blood transfusion? Yes / No When? _____ Reaction? Yes/No

Have you have any of the following?

		Testing	Date/Location
☐ Yes	☐ No	Chest X-Ray	_____
☐ Yes	☐ No	CT Scan	_____
☐ Yes	☐ No	Needle Bipsy	_____
☐ Yes	☐ No	Pulmonary Function Test	_____
☐ Yes	☐ No	Bronchoscopy	_____
☐ Yes	☐ No	Lung Surgery	_____

Patient Name: _____ **Date of Birth:** _____/_____/_____

SOUTHWEST PULMONARY ASSOCIATES

Review of Systems: *Please check if you* **currently** *have any of the following problems.*

General
□ Loss of appetite
□ Fatigue
□ Fever
□ Night sweats
□ Weight gain > 10 lbs
□ Weight loss <10 lbs

Skin
□ Excessive sweating
□ New skin lesions
□ Rash

HEENT
□ Runny nose
□ Nose bleeds
□ Nasal congestion
□ Sneezing
□ Seasonal allergies
□ Rhinitis
□ Hoarseness
□ Decreased sense of smell

Neck
□ Neck mass
□ Swollen neck glands

Hematology
□ Easy Bruising
□ Blood Clots

Neurological
□ Decreased memory
□ Headache
□ Seizures

Cardiovascular
□Difficulty with breathing when lying down
□ Irregular heart beats
□ Feeling smothered when lying flat (Orthopnea)
□ Shortness of breath (Dyspnea)
□ Swelling of the extremities

Gastrointestinal
□ Abdominal pain
□ Difficulty swallowing (Dysphagia)
□ Heartburn
□ Nausea/vomiting

Musculoskeletal
□ Joint pain
□ Joint swelling
□ Muscle cramps
□ Muscle pain (Myalgia)
□ Muscle weakness

Psychiatric
□ Anxiety
□ Depression
□ Excessive sleepiness (Hypersomnia)

SOUTHWEST PULMONARY ASSOCIATES

Patient Name: _____ **Date of Birth:** _____/_____/_____

Lung System Review	Condition	Date
☐ Yes ☐ No	Chronic cough _	_____
☐ Yes ☐ No	Wheezing _	_____
☐ Yes ☐ No	Asthma _	_____
☐ Yes ☐ No	Bronchitis _	_____
☐ Yes ☐ No	Sputum production _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _	_____
☐ Yes ☐ No	Tuberculosis _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _	_____
☐ Yes ☐ No	Pneumonia _	_____
☐ Yes ☐ No	Sleep apnea _	_____
☐ Yes ☐ No	Snoring _	_____
☐ Yes ☐ No	Shortness of breath with exertion _ _ _ _ _ _ _ _	_____
☐ Yes ☐ No	Shortness of breath with rest _ _ _ _ _ _ _ _ _ _ _	_____

Do you have any of the following already prepared?

☐Yes ☐ No Advance Directives (Living Will). If yes, where? _____

☐Yes ☐ No Durable Power of Attorney for Health Care. If yes, where? _____

☐Yes ☐ No Out of hospital DNR? _____

SOUTHWEST PULMONARY ASSOCIATES

Patient Name: _____ Date of Birth: _____/_____/_____

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 (zero) = would ***never*** doze
1 (one) = ***slight*** chance of dozing
2 (two) = ***moderate*** chance of dozing
3 (three) = ***high*** chance of dozing

SITUATION	CHANCE OF DOZING
Sitting and reading	_____
Watching TV	_____
Sitting, inactive in a public place (e.g., a theater or a meeting)	_____
As a passenger in a car for an hour without a break	_____
Lying down to rest in the afternoon when circumstances permit	_____
Sitting and talking to someone	_____
Sitting quietly after a lunch without alcohol	_____
In a car, while stopped for a few minutes in traffic	_____

Comments about your daytime sleepiness:_____
_____
_____
_____