

D. Conrad Harper, MD LLC

1400 N. Peterson Ave Suite C

Douglas, GA 31533

Tel: (912) 384-4000 Fax: (912) 384-4085

Dear: \_\_\_\_\_

Thank you for choosing Dr. Harper for your healthcare needs.

Your appointment has been scheduled for:

\_\_\_\_\_

Please fill out the packet and return it to the address above at your earliest convenience. Upon arrival for your appointment please have ready your picture I.D. and insurance cards as we will need a copy for your chart.

Thank you.

**D. CONRAD HARPER, MD LLC**

**1400 North Peterson Avenue**

**Suite C**

**Douglas, GA, 31533**

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To: Patients of Dr. Harper

As you all know, I feel screening techniques are very important and enable physicians to detect disease early with the intent to hopefully treat the disease in a successful manner. Therefore, I am going to recommend a very simple test for the early detection of colon cancer, i.e. "fecal occult blood". This test involves the collection of a stool sample followed by testing for very small amounts of blood. Current recommendations suggest this test be performed on an annual basis if you are over age 50. This test is also not intended to replace the need for a colonoscopy. Therefore, my staff will be reminding you of the need for this test if you are over age 50.

Thank you.

Dr. Harper

## **ATTENTION**

Please bring the following with you to your appointment.

1. All medication including over the counter medicine
2. Insurance cards
3. Payment

Your appointment may be rescheduled if you do not bring the items listed above.

If you need to reschedule your appointment, please call 24 hours ahead.

Thank you for your cooperation.

**D. Conrad Harper, M.D., L.L.C**  
**1400 North Peterson Avenue, Suite C**  
**Douglas, Georgia 31533**

**Patient's Rights and Responsibilities**

As a patient you have certain rights and responsibilities. We recognize a respectful relationship between the healthcare provider and the patient is the foundation of proper medical care.

Patients have the right to:

- Receive humane care and treatment with respect and consideration
- Privacy and confidentiality when seeking and receiving care except for life threatening conditions or situations
- Confidentiality of your health records
- Be informed of and to exercise the option to refuse to participate in any research aspect of your care without compromising access to medical care and treatment
- Receive accurate information concerning diagnosis, treatment, risks involved, and prognosis of an illness or health related condition.
- Ask about reasonable alternatives to care
- A second professional opinion regarding one's health care and treatment
- Participate actively in decisions regarding the scope and availability of services
- Be informed about any legal reporting requirements regarding any aspect of screening or care

Patients have the responsibility to:

- Provide complete information about one's illness/problem to enable proper evaluation and treatment
- Ask questions so that an understanding of the condition or problem is ensured
- Show respect to health personnel and other patients
- Reschedule/cancel an appointment to allow another person to be given the time slot...three(3) "no shows" may result in your dismissal from the practice
- Arrive for their scheduled appointments on time. Patients arriving 30 minutes late for their scheduled appointments will have to reschedule for another day.
- Pay bills or file health claims in a timely manner
- Use prescription or medical devices for oneself only
- Inform the practitioner(s) if one's condition worsens or an unexpected reaction occurs from a medication

## SUMMARY OF PRIVACY PRACTICES

This summary of our privacy practices is a condensed version of our notice of Privacy Practices. Our full length notice follows this summary.

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.

We understand that your medical information is personal to you, and we are committed to protecting your privacy. As your patient, we create medical records about your health, our care for you, and the services and/or items we provide to you as our patient. By law, we are required to make sure that your protected health information is kept private.

Here are a few examples of uses for your medical information. For more details, please refer to the notice of Privacy Practices that follows this summary.

- |  |   |
|--|---|
| *For medical treatment                   | *For research   |
| *To obtain payment                       | *To avert a serious threat to health & safety                             |
| *In emergency situations                 | *For organ and tissue donation  |
| *Appointment recall reminders            | *For worker's compensation programs                                       |
| *To run practice efficiently/effectively | *In response to certain request arising out of lawsuits or other disputes |

If you believe your privacy rights have been violated, you may file a complaint with the practice of the Secretary of the Department of Health and Human Services. To file a complaint you may contact our privacy officer, Steve Bailey at (912) 384-4000 EXT: 202. All complaints must be submitted in writing and you will not be penalized for filing a complaint.

You have certain rights regarding the information we maintain about you. These rights include:

- |  |   |
|--|---|
| *The right to inspect and copy             | *The right to request restrictions                |
| *The right to amend                        | *The right to a paper copy of this notice         |
| *The right to an accounting of disclosures | *The right to request confidential communications |

For more information about these rights, please review the detailed Notice of Privacy Practice that follows this summary.

## FINANCIAL POLICY

1. Payment is due at the time of service. You may also be asked to pay old balances in full before and appointment can be scheduled.
2. If you have insurance, please present us with your card and verify your current address and phone number.
3. If your insurance company requires a co-pay, we are required to collect this amount before you leave today.
4. We will bill your insurance company for their portion; however, if the payment is not received within a reasonable timeframe, you will be asked to pay the old balance.
5. If you have insurance coverage with a company that we do not have a contract with for payment claims, you will be asked to cover the full cost of today's visit. We will be glad to file your claim and proceeds will be paid directly to you as the "insured".
6. Not all procedures are covered by your insurance. Payment for these procedures will be your responsibility. Therefore, you may wish to check with your insurance company or obtain verification before these procedures are scheduled.
7. If you do not have insurance, you will be considered a "self-pay". The fee or charge will be adjusted to reflect a discount for services rendered.
8. Medicare patients are required by Federal Law to pay their co-payments and their deductible that is not covered by Medicare. Please let us know if you have a supplemental policy that will cover this co-payment.
9. NONPAYMENT- balances over 90 days will be brought to the attention of Dr. Harper and the Office Administrator. Efforts will be made to establish a payment plan to meet one's budget and basis for discharge from the practice. We ask for your cooperation regarding this matter.
10. MISSED APPOINTMENTS- An excessive number of missed appointments not cancelled within a reasonable time frame will result in your dismissal from this practice. Please call in advance to cancel your appointment to allow us to offer this time slot to someone else in need of medical service.
11. If you have questions regarding your balance, please obtain clarification and make payment arrangements with our check-out clerk today before you leave.
12. Otherwise, we appreciate you choosing our office as your health care professional and will make every effort to provide high quality service.

I have read and understood the payment policy and agree to abide by its guidelines.

\_\_\_\_\_  
Patient or Responsible Party Signature

\_\_\_\_\_  
Date

This agreement will be scanned and made a permanent part of your healthcare record.

D. Conrad Harper, M.D., L.L.C.  
1400 North Peterson Avenue  
Suite C-Douglas, Georgia 31533  
(912) 384-4000

Patient Information

First & Last Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_

Male or Female \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Marital Status: S M D W \_\_\_\_\_ Social Security Number: \_\_\_\_\_ Pharmacy Preferred: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

Physical Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Employer: \_\_\_\_\_ Work Phone Number: \_\_\_\_\_

Spouse Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Email Address: \_\_\_\_\_

Is This Visit A Hospital Follow Up? Yes or No \_\_\_\_\_ Dates in Hospital: \_\_\_\_\_

Assignment & Release

Attention Medicare Patients: We are required by law to collect a Co-Payment that is not covered by Medicare. Please let us know if you have a supplemental policy that might cover this co-payment. Under the Federal law governing Medicare, you are mandated by law to pay your deductible and a 20% co-payment.

I, the undersigned certify that I (or my dependent) have insurance coverage with \_\_\_\_\_, and assign directly to Dr. Conrad Harper all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the release of any/ all of my medical records to any insurance company and to any referred doctor(s).

If you have an unpaid balance 90 days after the Insurance payments have been received, we will put you on a monthly payment plan. Our billing office will contact you to make those arrangements or you can pay your balance on a credit card. By signing below you acknowledge that you understand this policy.

X \_\_\_\_\_

(Responsible Party Signature)

(Relationship)

(Date)

Insurance Policy Holder Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**D. Conrad Harper, M.D., L.L.C.**

1400 North Peterson Avenue, Suite C

Douglas, Georgia 31533

Phone (912) 384-4000, Fax (912) 384-4085

**Medical Records Release Form**

Date: \_\_\_\_\_

Doctor's Name & Address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please release all medical records on the following patient to:

D. Conrad Harper, M.D., L.L.C.

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

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

Patient Address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



D. Conrad Harper, M.D., L.L.C  
1400 North Peterson Avenue, Suite C  
Douglas, Georgia 31533

Consent for Use or Disclosure of Protected Health Information for Payment, Treatment, and Health Care  
Options

By signing below, you hereby consent for this practice to use or disclose information about yourself ( or another person for which you have the authority to sign) that is protected under federal law, for the sole purposes of treatment, payment and health care operations, You may refuse to sign this form; however, your diagnosis and treatment may be conditioned upon your consent as evidenced by your signature on this form.

You should read the Notice of Privacy Practices for Protected Health Information (PHI) attached to this form before signing the consent. The terms of the notice may change from time to time, and you may always get a revised copy by asking the Privacy Officer of this practice.

You have the right to request that the practice restrict how PHI is used or disclosed to carry out treatment, payment, or health care operations. The practice is not required to agree to requested restrictions; however, if the practice agrees to your requested restrictions, the restriction is binding on it.

Information about you is protected under Federal Law, and you have the right to revoke this consent, unless we have taken action in reliance on your authorization (as determined by our Privacy Officer). By signing below, you recognize that the protected health information used or disclosed pursuant to this consent may be subject to re-disclosure by the recipient and may no longer be protected under Federal Law.

You may communicate with the following individuals regarding my condition or course of treatment:

---

You may communicate confidential information to me, including invoices for services, to the following address and phone numbers:

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\_\_\_\_\_  
Individual Signature

\_\_\_\_\_  
Date

As a personal representative, I have authority to act for the Individual because I am the individual's:

---

TO: DR. HARPER'S PATIENTS

TEST RESULT NOTIFICATION POLICY

MY STAFF AND I WILL REVIEW TEST RESULTS AS SOON AS WE RECEIVE THE RESULTS. YOU WILL RECEIVE A NOTIFICATION VIA MAIL FOR NON-URGENT RESULTS. HOWEVER, IF THE RESULT IS CRITICAL, THEN MY STAFF AND I WILL MAKE EVERY EFFORT TO CONTACT YOU BY PHONE AS SOON AS POSSIBLE.

OTHERWISE, IF YOU HAVE NOT RECEIVED NOTIFICATION OF TEST RESULTS IN 7-10 DAYS, THEN PLEASE CALL MY OFFICE. WE ALSO ASK FOR YOUR COOPERATION AND PATIENCE REGARDING THIS ISSUE.

THANK YOU,

DR. HARPER

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PATIENT SIGNATURE

---

DATE

## Medical History Form

Fill in the information below as completely as possible.

Name: \_\_\_\_\_ Age: \_\_\_\_\_

### YOUR CURRENT MEDICATIONS:

<u>Name of Medication</u>	<u>Dosage</u>	<u>How Many Times Per Day</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

### LIST ANY ALLERGIES TO MEDICATIONS:

<u>Name of Medication</u>	<u>What reaction did you have?</u>
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

### HAVE YOU EVER BEEN TREATED FOR ANY OF THE FOLLOWING MEDICAL PROBLEMS?

<u>Medical Problem</u>	<u>Circle One</u>	<u>Give Details</u>
Heart Disease	Yes/No	_____
Diabetes	Yes/No	_____
High Blood Pressure	Yes/No	_____
Lung Disease	Yes/No	_____
Asthma	Yes/No	_____
Cancer	Yes/No	_____
Thyroid Problems	Yes/No	_____
Ulcers	Yes/No	_____
Blood Transfusions	Yes/No	_____
Kidney Problems	Yes/No	_____
Arthritis	Yes/No	_____
Seizures	Yes/No	_____
Breast Problems	Yes/No	_____
Sexually Transmitted Disease	Yes/No	_____
Any Other	Yes/No	_____

RECENT SYMPTOMS:

(List any symptoms you are having or had recently.)

GENERAL

Hay Fever	YES/NO
Sneezing	YES/NO
Sinus Problems	YES/NO
Prolonged Fevers	YES/NO
Weight Loss/Gain	YES/NO

EYES

Recent change in Vision	YES/NO
Drainage from Eyes	YES/NO

CARDIOVASCULAR

Chest Pain or Tightness	YES/NO
Irregular Heart Beat	YES/NO
Episodes of Heart Fluttering	YES/NO
Fainting or Dizziness	YES/NO
Increasing Shortness of Breath	YES/NO
Short of Breath when laying flat	YES/NO
Wake up at night short of breath	YES/NO
Swelling of legs	YES/NO
Excessive Fatigue	YES/NO

LUNG HISTORY

Wheezing or asthma attacks	YES/NO
Chronic Cough	YES/NO
Cough up blood	YES/NO
Painful breathing	YES/NO
Excessive Snoring	YES/NO
Difficulty staying awake during the day	YES/NO
Episodes of Stopping breathing at night	YES/NO

GASTROINTESTINAL

Frequent Heartburn or Indigestion	YES/NO
Pain or difficulty when swallowing	YES/NO
Vomiting Blood	YES/NO
Red blood in stool	YES/NO
Black, tarry stools	YES/NO
Chronic Diarrhea	YES/NO
Chronic Constipation	YES/NO
Abdominal Pain	YES/NO

URINARY

Blood in urine	YES/NO
Difficult passing urine	YES/NO
Urge to urinate too frequent	YES/NO
Frequent urination at night	YES/NO
Painful urination	YES/NO

SKIN

Skin lesions or moles that concern you	YES/NO
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NEUROLOGICAL

Seizures or Epilepsy	YES/NO
Stroke or stroke-like symptoms	YES/NO

PSYCHIATRIC

Anxiety	YES/NO
Depression	YES/NO

MUSCULOSKELETAL

History of joint pain or arthritis	YES/NO
Low Back Pain	YES/NO
Neck Pain	YES/NO

PAST SURGICAL HISTORY:

(Please list previous surgeries and the year the surgeries were performed.)

WOMEN'S HEALTH HISTORY:

Total number of pregnancies \_\_\_\_\_

Number of live births \_\_\_\_\_

Stillbirths/Miscarriages/Abortions \_\_\_\_\_

Date of your last Pap smear \_\_\_\_\_

Date of your last mammogram \_\_\_\_\_

Date of your last menstrual period \_\_\_\_\_

FAMILY MEDICAL HISTORY:

(List medical problems of any relatives.)

Medical Problem	Which Relative	Give Details
Heart Disease	_____	_____
Diabetes	_____	_____
Stroke	_____	_____
Cancer	_____	_____
High Cholesterol	_____	_____
High Blood Pressure	_____	_____
Other Problems	_____	_____

Father: \_\_\_\_\_ Living, His Age \_\_\_\_\_

\_\_\_\_\_ Died, at age \_\_\_\_\_ from what cause \_\_\_\_\_

Mother: \_\_\_\_\_ Living, Her Age \_\_\_\_\_

\_\_\_\_\_ Died, at age \_\_\_\_\_ from what cause \_\_\_\_\_

Number of brothers: \_\_\_\_\_ Number of sisters: \_\_\_\_\_

SOCIAL HISTORY:

Circle one: Single/Married/Divorced/Widowed

Number of children: \_\_\_\_\_ Your Occupation: \_\_\_\_\_

Smoking (check one): \_\_\_\_\_ I have never smoked  
\_\_\_\_\_ I smoked previously but quit.  
How much: \_\_\_\_\_ for how long: \_\_\_\_\_ Quit when: \_\_\_\_\_  
\_\_\_\_\_ I currently smoke  
How much: \_\_\_\_\_ for how long: \_\_\_\_\_

Do you drink alcoholic beverages: YES/NO If yes, how much/how often: \_\_\_\_\_

## BALANCE SELF TEST

### ARE YOU AT RISK FOR FALLS?

- |   |     |    |
|---|-----|----|
| *Have you fallen in the past year?  | YES | NO |
| *Do you lose your balance when standing?  | YES | NO |
| *Do you lose your balance when you initially get up after sitting?  | YES | NO |
| *Do you get dizzy, faint or have seizures?  | YES | NO |
| *Does it take you more than one try to get up out of a chair or out of bed?                                   | YES | NO |
| *Do you trip over your own feet or objects on the floor?  | YES | NO |
| *Do you take corners too sharp; bump into corners or door frames?   | YES | NO |
| *Do you use a walker, cane or need assistance to get around?  | YES | NO |
| *Do you lose your balance, feel unsteady or stagger when walking?   | YES | NO |
| *Have you had a recent loss of or decrease in vision or hearing?  | YES | NO |
| *Do you have numbness or loss of sensation in your feet or legs?  | YES | NO |
| *Have you experienced a stroke, accident or any other health problems<br>that may have affected your balance? | YES | NO |

**If you have answered yes to one or more questions, you may have a balance problem. If you are concerned about falling, you should speak with your physician.**

Patient Name (Printed): \_\_\_\_\_ SSN: \_\_\_\_\_

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

## Berlin Questionnaire Sleep Evaluation

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

1. Do you snore?

- ☐ Yes
- ☐ No
- ☐ Not Sure

*If you snore....*

2. Is your snoring

- ☐ Slightly louder than breathing
- ☐ As loud as talking
- ☐ Louder than talking
- ☐ Very loud. Can be heard in adjacent rooms.

3. How often do you snore?

- ☐ Nearly everyday
- ☐ 3-4 times a week
- ☐ 1-2 times a week
- ☐ 1-2 times a month

4. Has your snoring ever bothered other people?

- ☐ Yes
- ☐ No

5. Has anyone noticed that you quit breathing during your sleep?

- ☐ Nearly everyday
- ☐ 3-4 times a week
- ☐ 1-2 times a week
- ☐ 1-2 times a month

6. How often do you feel tired or fatigued after you sleep?

- ☐ Nearly everyday
- ☐ 3-4 times a week
- ☐ 1-2 times a week
- ☐ 1-2 times a month

7. Do you feel tired or fatigued during your wake time?

- ☐ Nearly everyday
- ☐ 3-4 times a week
- ☐ 1-2 times a week
- ☐ 1-2 times a month

8. Have you ever nodded off or fallen asleep while driving a vehicle?

- ☐ Yes
- ☐ No

*If yes, how often does it occur?*

- ☐ Nearly everyday
- ☐ 3-4 times a week
- ☐ 1-2 times a week
- ☐ 1-2 times a month

9. Do you have high blood pressure?

- ☐ Yes
- ☐ No

This survey asks questions about you, your breathing and what you are able to do. To complete the survey, mark an X in the box that best describes your answer for each question below.

1. During the past 4 weeks, how much of the time did you feel short of breath?

None of the time	A little of the time	Some of the time	Most of the time	All of the time
<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>2</sub>

2. Do you ever cough up any "stuff" such as mucus or phlegm?

No, never	Only occasional colds or chest infections	Yes, a few days a month	Yes, most days a week	Yes, everyday
<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>

3. Please select the answer that best describes you in the past 12 months. I do less than I used to because of my breathing problems

Strongly disagree	Disagree	Unsure	Agree	Strongly agree
<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>

4. Have you smoked at least 100 cigarettes in your ENTIRE LIFE?

No	Yes	Don't Know
<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>0</sub>

5. How old are you?

35-49	50-59	60-69	70+
<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>2</sub>

How to score the survey: In the spaces below, write the number that is next to your answer for each of the questions. Add the numbers to get the total score. The total score can range from 0 to 10.

\_\_\_\_\_ + \_\_\_\_\_ + \_\_\_\_\_ + \_\_\_\_\_ + \_\_\_\_\_ = \_\_\_\_\_

#1      #2      #3      #4      #5      Total:

Please share the completed survey with your doctor.



## FATIGUE SEVERITY SCALE (FSS) OF SLEEP DISORDERS

The Fatigue Severity Scale (FSS) 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 questionnaire contains nine statements that rate the severity of your fatigue symptoms. Read each statement and circle a number from 1 to 7, based on how accurately it reflects your condition during the past week and the extent to which you agree or disagree that the statement applies to you.

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

FSS QUESTIONNAIRE							
During the past week, I have found that:	<div style="display: flex; align-items: center; justify-content: space-between;"> <span>Disagree</span> <span>←————→</span> <span>Agree</span> </div>						
My motivation is lower when I am fatigued.	1	2	3	4	5	6	7
Exercise brings on my fatigue.	1	2	3	4	5	6	7
I am easily fatigued.	1	2	3	4	5	6	7
Fatigue interferes with my physical functioning.	1	2	3	4	5	6	7
Fatigue causes frequent problems for me.	1	2	3	4	5	6	7
My fatigue prevents sustained physical functioning.	1	2	3	4	5	6	7
Fatigue interferes with carrying out certain duties and responsibilities	1	2	3	4	5	6	7
Fatigue is among my three most disabling symptoms.	1	2	3	4	5	6	7
Fatigue interferes with my work, family, or social life.	1	2	3	4	5	6	7
	<b>TOTAL SCORE:</b>						

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Scoring your results.

Now that you have completed the questionnaire, it is time to score your results and evaluate your level of fatigue. It's simple: Add all the numbers you circled to get your total score.

### THE FATIGUE SEVERITY SCALE KEY

A total score of less than 36 suggests that you may not be suffering from fatigue.

A total score of 36 or more suggests that you may need further evaluation by a physician.

## EPWORTH SLEEPINESS SCALE

You can use the form below to determine your sleepiness level. For each situation, choose a number based on the scale below. When you finish entering all responses, add the total of your score and enter it at the bottom. It is important to select one answer (0 to 3) for each of the 8 situations below.

PLEASE USE THE FOLLOWING SCALE:

- 0=Would never doze off
- 1=Slight chance of dozing
- 2=Moderate chance of dozing
- 3=High chance of dozing

Situation	Chance of dozing (0 to 3)			
	0	1	2	3
Sitting and reading	0	1	2	3
Watching television	0	1	2	3
Sitting inactive in a public place—for example, a theater or 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	0	1	2	3
Sitting and talking to someone	0	1	2	3
Sitting quietly after lunch (when you've had no alcohol)	0	1	2	3
In a car while stopped in traffic	0	1	2	3
Total Score:				

### THE EPWORTH SLEEPINESS SCALE KEY:

- A total score of less than 10 suggest that you are not suffering from excessive daytime sleepiness.
- A total score of 10 or more suggest that you may need further evaluation by a physician to determine the cause of your excessive sleepiness and whether you have an underlying sleep disorder.

### YOUR NEXT STEPS:

This scale should not be used to make your own diagnosis. It is intended as a tool to help you identify your own level of daytime sleepiness, which is a symptom of many sleep disorders.

If your score is 10 or more, please share this information with your physician. Be sure to describe all your symptoms, as clearly as possible, to aid in your diagnosis and treatment.

It is important to remember that true EDS is almost always caused by an underlying medical condition that can be easily diagnosed and effectively treated.