PATIENT NAME:	DOB:

Cernero Surgery & Aesthetics
GENERAL & BARIATRIC SURGERY

(PLEASE PRINT LEGIBLY, add as much detail as possible and use BLACK OR DARK BLUE INK.)

MEDICALLY SUPERVISED TREATMENT REGIMENS: (Please only complete if interested in weight loss)

Medication	Yes	No	From	To	Physician
Phentermine	☐	☐			
Fen-Phen	☐	☐			
Redux	☐	☐			
Contrave	☐	☐			

OTHER WEIGHTLOSS METHODS:

Method	Yes	No	From	To	Method	Yes	No	From	To
Advocare	☐	☐			Medifast	☐	☐		
Atkins	☐	☐			Nutrisystem	☐	☐		
Herbalife	☐	☐			Slim Fast	☐	☐		
Jenny Craig	☐	☐			Weight Watchers	☐	☐		
Metabolife	☐	☐			Other:	☐	☐		

Maximum weight lost on ANY program:

Have you ever been treated for an eating disorder:

If Yes, please describe treatment, duration, and year:

"S.T.O.P. – B.A.N.G." Sleep Apnea Questionnaire (Please only complete if interested in weight loss)

Please complete this form to the best of your knowledge	**YES**	**NO**
Do you **SNORE** loudly?	☐	☐
Do you often feel **TIRED** during the daytime?	☐	☐
Has anyone ever **OBSERVED** you stop breathing while sleeping?	☐	☐
Do you have or are you being treated for high blood **PRESSURE**?	☐	☐
Is your **BMI** more that 35kg/m²?	☐	☐
AGE over 50?	☐	☐
NECK circumference greater than 17 inches (men)/16 inches (women)?	☐	☐
GENDER?	male ◯	female ◯

SYMPTOMS OF SLEEP DISORDERS (Please only complete if interested in weight loss)
PLEASE ☑ ALL THAT APPLY

☐ Insomnia or inability to sleep well	☐ Irregular breathing during sleep
☐ Excessive daytime sleepiness or napping	☐ Loss of Energy – Fatigue
☐ Loud snoring	☐ Lack of concentration
☐ Morning headaches	☐ Confusion
☐ Uncomfortable sensations or jerking of the limbs	☐ Leg Swelling
☐ Restless Sleep or "tossing and turning"	☐ Difficulty getting to sleep or staying asleep
☐ Weight Gain or Obesity	☐ Vivid, frightening, or violent dreams
☐ Personality Changes	

PATIENT NAME:	DOB:

Epworth Sleepiness Scale (Please only complete if interested in weight loss)

This questionnaire was developed to determine the level of daytime sleepiness in individuals. It has become one of the most frequently used methods for determining a person's average level of daytime sleepiness.

Please rate how likely you are to doze or fall asleep in the following situations by selecting the response that best applies. If you have not done some of these activities recently, select what would most likely happen if you were in that situation.

0	1	2	3
Would **never** doze	**Slight** chance of dozing	**Moderate** chance of dozing	**High** chance of dozing

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

Interpreting Epworth Sleepiness Scale Scores[1],[2]		
Normal	EDS*	High Levels of EDS*
0-10	>10	>16

Signature of Patient or Legal Representative Date

[1]**Sources**: 1. Johns M, Hocking B. Excessive daytime sleepiness: daytime sleepiness and sleep habits of Australian workers. *Sleep* 1997;20(10):844-849. 2. Johns MW. A new method of featuring daytime sleepiness: the Epworth sleepiness scale. *Sleep*. 1991;14(6): 540-545.

*Excessive daytime sleepiness.

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