Please complete and mail, fax, e-mail, or drop off to:

Bariatric Program Coordinator
Mercy General Surgery Clinic
788 8th Ave. SE, Level 3, Suite 300
Cedar Rapids, IA. 52401
Fax: (319) 398-6748 Phone: (319) 398-6747
bariatrics@mercycare.org

MERCY®
BARIATRIC SURGERY CLINIC

Full Name:_____Maiden Name:_____Date:_____

Age:_____Date of Birth:_____/_____/_____ Sex: MALE FEMALE OTHER _____

Ethnicity: American Indian or Alaska Native Asian Black or African American White Hispanic
Native Hawaiian or Other Pacific Islander Unknown Other: _____

Address:_____ City:_____State:_____Zip code:_____

Mobile Phone: (_____)_____-_____ Alternate Phone: (_____)_____-_____

Email:_____SSN (Last 4 Digits):_____

Occupation:_____ Full-time Part-time Unemployed Retired Student Disabled

Employer:_____ Type of work: _____

**INSURANCE:**

**Primary Insurance:**_____

ID#:_____Group#:_____

Policyholder (Subscriber Name):_____ Relationship:_____

Customer Service Phone Number:_____Subscriber Date of Birth: ____/_____/_____

**Secondary Insurance:**_____

ID#:_____Group#:_____

Policyholder (Subscriber Name):_____ Relationship:_____

Customer Service Phone Number:_____Subscriber Date of Birth: ____/_____/_____

**Have you attended or registered for one of the mandatory bariatric surgery informational seminar?** YES NO

Date attended or date planning to attend: _____

**EMERGENCY CONTACT:**

Name:_____ Relationship: _____

Address: _____ Phone Number: (_____) _____ - _____

**REFERRING PROVIDER:**

Name:_____

Clinic Phone: (_____) _____ - _____

Clinic Fax: (_____) _____ - _____

Has a referral been placed to the Mercy General Surgery Clinic for the Bariatric Surgery Program? Yes No

**If a referral has not been placed, please contact your provider to get one sent either by fax to (319) 398-6748 or through Epic order for Ambulatory Referral to Bariatric Surgery**

**PRIMARY CARE PROVIDER:**

Name:_____

Clinic Phone: (_____) _____ - _____

Clinic Fax: (_____) _____ - _____

Have you discussed your interest in pursuing bariatric surgery with your primary care provider? Yes No

****If no, please inform your primary care provider of you interest in pursuing bariatric surgery****

**Name and addresses of other physicians you have seen in the past five years:**

| Specialty | Address | Phone | Fax |
|---|---|---|---|
| Cardiologist: | | | |
| Pulmonologist: | | | |
| Endocrinologist: | | | |
| OBGYN: | | | |

**What type of weight loss surgery are you interested?**

Gastric Bypass (RNY, Roux-n-Y Sleeve Gastrectomy (Sleeve) Adjustable Gastric Band (Lap Band)

Revision Surgery Unsure

- What type of bariatric surgery did you have previously?
- When was your previous bariatric surgery performed?
- Where was your previously bariatric surgery performed?
- What is your reason for seeking a revision?

## *Questions to Ask Your Insurance Company about Bariatric* (Metabolic) Surgery

It is required that you contact your insurance company to verify if your plan covers metabolic surgery **before** you get scheduled for your new patient orientation day and initial consult. If you have secondary coverage, please ask the same questions as we will need those responses as well.

*****This step is a REQUIREMENT prior to turning in your health questionnaire*****

*If you intend to use Medicare to cover your bariatric procedure, be advised that they do not have a pre-authorization system. You will not know if you are covered until after the procedure. Be sure to ask Medicare to provide a list of requirements for coverage*

**Insurance Company: _____ I spoke with: _____**

**Question to ask if you have Iowa Total Care for your insurance provider: Am I on the health and wellness plan? YES NO**

**Date you called: _____Reference # for call _____**

1. Is bariatric (metabolic) surgery covered on my insurance plan? YES NO
   a. Is it an exclusion? YES NO
      (If you have an exclusion, your insurance **will not** cover it even if it is medically necessary).
   ***Other terminology your insurance carrier may use is "Treatment for morbid obesity" or "Weight Loss Surgery"***
   ***Your insurance may ask for CPT codes***:
   43644- Lap Gastric Bypass 43775- Lap Sleeve Gastrectomy
   43645- Lap Gastric Bypass to limit absorption 43770- Lap Band

If you have previously undergone any weight loss procedures (i.e. lap band, VBG, sleeve gastrectomy, bypass, etc) please ask the following questions:

   b. Is revisional bariatric surgery covered under my plan? YES NO
   c. Are there any specific requirements that need to be met prior to undergoing revisional bariatric surgery? If yes, please list:_____

2. Is Mercy Medical Center in my network for bariatric surgery? (NPI 1720029333) **YES** **NO**
   Hospital Address: 701 10th St. SE-Cedar Rapids, IA 52403

3. Is Dr. Ahad a covered specialist? (NPI 1326024837) **YES** **NO**
   Clinic Address: 788 8th Ave. SE-Suite 300, Cedar Rapids, IA 52401

4. Do I have to go to a **Center of Excellence** for my procedure? **YES** **NO**
5. Do I have to go to a **Blue Distinction Center** to have my procedure? **YES** **NO**
   ***Mercy Medical Center is considered a Center of Excellence.***
   ***Blue Distinction Center at this time. We are in the process of becoming one but uncertain as to when that will occur.***
6. Are nutrition services a covered benefit? They may ask for CPT codes.
   **97802**- Initial Assessment **97803**- Reassessment and Intervention
7. Does my insurance plan require a certain number of dietitian visits prior to bariatric surgery? **YES** **NO**
   a. If yes, how many? _____
8. Does my insurance plan require a certain number of months in the program? **YES** **NO**
   a. If yes, how many? _____
9. Do I need a psychiatric evaluation? They may ask for CPT codes.
   **90791**- Psychological Diagnostic Evaluation **96130**- Psychiatric Testing
10. Do my benefits start every calendar year or every fiscal year? **CALENDAR** **FISCAL YEAR**
11. How much is my deductible and how much is remaining? _____
12. Do I have co-insurance, if so, what is the percentage? _____
13. How much is my out-of-pocket and how much is remaining? _____
14. What is my specialist copay? _____

**DRUG ALLERGIES** (If none- leave blank. Please list any additional allergies on the back of this form.):

| Drug | Reaction | Drug | Reaction |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

**MEDICATIONS-** Please list all medications you take including herbal and over-the-counter

| Name of medication | Dosage | Frequency | Reason for taking | How long have you been taking? |
|---|---|---|---|---|
| | | | | |
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**If more room is needed to add medications, please add to back of this page or attach medication list**

**PREGNANCY HISTORY:**(Please list any additional pregnancies on the back of this page):

| Pregnancy | Year | Weight at start | Weight at delivery |
|---|---|---|---|
| #1 | | | |
| #2 | | | |
| #3 | | | |
| #4 | | | |

**Current method of birth control:**

Pill Condoms

Surgical IUD

Implant Injection

Patch Other: (please specify)

**MEDICAL HISTORY-** Please indicate **YOUR** medical history

| Condition | Past or Now | Medication | Dose and Frequency |
|---|---|---|---|
| High blood pressure - hypertension | **Past Now N/A** | | |
| Diabetes | **Past Now N/A** | | |
| Sleep apnea | **Past Now N/A** | | |
| Daytime sleepiness | **Past Now N/A** | | |
| Snoring | **Past Now N/A** | | |
| Heartburn | **Past Now N/A** | | |
| GERD | **Past Now N/A** | | |
| Heart disease | **Past Now N/A** | | |
| COPD | **Past Now N/A** | | |
| High cholesterol | **Past Now N/A** | | |
| Joint pain | **Past Now N/A** | | |
| Back pain | **Past Now N/A** | | |
| Hip pain | **Past Now N/A** | | |
| Knee pain | **Past Now N/A** | | |
| Ankle/Foot pain | **Past Now N/A** | | |
| Swelling of feet | **Past Now N/A** | | |
| Urinary incontinence | **Past Now N/A** | | |
| Blood clots | **Past Now N/A** | | |
| Deep vein thrombosis (DVT) | **Past Now N/A** | | |
| Pulmonary embolism (PE) | **Past Now N/A** | | |
| Stroke | **Past Now N/A** | | |
| Shortness of breath | **Past Now N/A** | | |
| Asthma | **Past Now N/A** | | |
| Emphysema | **Past Now N/A** | | |
| Headaches | **Past Now N/A** | | |
| Migraines | **Past Now N/A** | | |
| Kidney disease | **Past Now N/A** | | |
| Seizures | **Past Now N/A** | | |
| Arthritis | **Past Now N/A** | | |
| Cancer | **Past Now N/A** | | |
| Rashes | **Past Now N/A** | | |
| Irregular periods | **Past Now N/A** | | |
| Fatty liver | **Past Now N/A** | | |
| Other (please specify): | **Past Now N/A** | | |

**SURGICAL HISTORY:** Please list any other surgery **not listed** here on the back of this page:

| Procedure | Yes or No | Date of Surgery | Open or Laparoscopic | Where was surgery performed? |
|---|---|---|---|---|
| Tubal Ligation | **Yes No** | | **Open Laparoscopic** | |
| Tonsillectomy | **Yes No** | | **Open Laparoscopic** | |
| Appendectomy | **Yes No** | | **Open Laparoscopic** | |
| Hysterectomy | **Yes No** | | **Open Laparoscopic** | |
| Back Surgery | **Yes No** | | **Open Laparoscopic** | |
| Heart Bypass (CABG) | **Yes No** | | **Open Laparoscopic** | |
| Arthroscopy | **Yes No** | | **Open Laparoscopic** | |
| Intestine Surgery | **Yes No** | | **Open Laparoscopic** | |
| Joint Replacement | **Yes No** | | **Open Laparoscopic** | |
| Cholecystectomy (gallbladder) | **Yes No** | | **Open Laparoscopic** | |
| Total Hysterectomy | **Yes No** | | **Open Laparoscopic** | |
| Cesarean Section (C-Section) | **Yes No** | | **Open Laparoscopic** | |
| Abdominal Hernia Repair | **Yes No** | | **Open Laparoscopic** | |

**Have you ever had any trouble with anesthesia? YES NO If yes, what? _____**

**SOCIAL HISTORY:**

Do you currently smoke cigarettes, vape, or use any other form of tobacco? Yes No

How much or how often do you smoke or use tobacco?

How long have you smoked, vaped, or used tobacco?

Have you ever **PREVIOUSLY** smoked, vaped, or used tobacco? Yes No

How much or how often did you smoke, vape, or use tobacco?

How long ago did you **COMPLETELY** quit?

Do you currently consume alcohol? Yes No

How much or how often do you consume alcohol?

Have you ever received treatment for alcohol use? Yes No

What year? How long?

Do you currently or have you **EVER** used legal or illegal drugs for recreational purposes? Yes No

What types of legal or illegal drugs do/did you use for recreational purposes?

How much or how often do/did you use legal or illegal drugs for recreational purposes?

Have you ever received treatment for abuse of legal or illegal drug use? Yes No

What year? How long?

**FAMILY HISTORY** – (Please X all appropriate boxes):

| Family Member | Cancer (what type) | Obesity | Diabetes | Early Death | Heart Disease | High blood pressure | Other |
|---|---|---|---|---|---|---|---|
| Mother | | | | | | | |
| Father | | | | | | | |
| Sister | | | | | | | |
| Brother | | | | | | | |
| Daughter | | | | | | | |
| Son | | | | | | | |
| Maternal Aunt (mother's sisters) | | | | | | | |
| Maternal Uncle (mother's brothers) | | | | | | | |
| Paternal Aunt (father's sisters) | | | | | | | |
| Paternal Uncle (father's brothers) | | | | | | | |
| Maternal Grandmother (mother's mother) | | | | | | | |
| Maternal Grandfather (mother's father) | | | | | | | |
| Paternal Grandmother (father's mother) | | | | | | | |
| Paternal Grandfather (father's father) | | | | | | | |
| Other | | | | | | | |
| Family History Unknown: | Adopted | | | | | | |

## BARIATRIC ASSESSMENT

**ABUSE HISTORY:**

| | | | | | |
|---|---|---|---|---|---|
| **Physical Abuse:** | No | Yes, past | Yes, present | Yes, past and present | Other |
| **Sexual Abuse:** | No | Yes, past | Yes, present | Yes, past and present | Other |
| **Verbal Abuse:** | No | Yes, past | Yes, present | Yes, past and present | Other |

## EDUCATION/EMPLOYMENT HISTORY:

**Education:**

9-11 years | High School Graduate | Vocation/Technical School | Attending College | College Graduate | Graduate Degree | Doctoral Degree | Other

## WEIGHT HISTORY:

My obesity started (circle the most appropriate response):

In childhood  After pregnancy  As an adult  After a traumatic or stressful event

Lowest adult weight:_____At what age?_____ Highest adult weight:__At what age? _____

Lowest weight in past 5 years: _____ Highest weight in past 5 years: _____

Most weight lost on any program:_____ Program type/name:_____

Current weight in pounds:_____BMI:_____ Current height in Feet:_____Inches:_____

## SUPPORT SYSTEM:

Mother  Father  Spouse  Significant Other  Sibling  Friend  Other

## MENTAL HEALTH SYMPTOMS: Circle ALL symptoms that you have experienced in the past month

**Depression Symptoms:**

| | | | | | |
|---|---|---|---|---|---|
| Appetite Changes | Change in Energy Level | Crying | Decreased Libido | Isolative | Feelings of Helplessness |
| Feelings of Hopelessness | Feelings of Worthlessness | Impaired Concentration | Increased Irritability | Loss of Interest | Panic/Anxiety |
| Psychomotor Retardation | Sleep Disturbance | Suicidal Ideations | Thoughts of Harming Yourself | None of the Above | Other (Specify) |

**Mania Symptoms:**

| | | | | | | |
|---|---|---|---|---|---|---|
| Flight of ideas | Grandiosity | Hypersexuality | Increased Energy | Increased Spending | Labile | Less Need to Sleep |
| Poor Judgment | Pressured Speech | Rapid Cycling | Psychomotor Agitation | None of the Above | Other (Specify) | |

**Anxiety Symptoms:**

| | | | | | | |
|---|---|---|---|---|---|---|
| Generalized Anxiety | Panic Attacks | Chest Pain | Compulsive Behavior | Excessive Counting | Excessive Sweating | Feelings of Doom |
| Obsessions | Palpitations | Ritualistic Behaviors | Social Phobias | Unexplained Fears | None of the Above | Other (Specify) |

**Obsessive Compulsive (OCD) Symptoms:**

| Fear of Contamination by Germs/Dirt | Fear of Causing Harm to Another | Fear of Making a Mistake/Being Embarrassed | Need for Symmetry, Order, or Exactness | Repetitive Behaviors | Collecting/Hoarding with No Apparent Value | None of the Above | Other (Specify) |
|---|---|---|---|---|---|---|---|

**Sleep Concerns:**

| Difficulty Falling Asleep | Excessive Sleeping | Insomnia | Nightmares/Fears | Sleep Disruption | Sleep Routine | Sleep-Walking | None of the Above | Other (Specify) |
|---|---|---|---|---|---|---|---|---|

**MENTAL HEALTH HISTORY:**

| | | |
|---|---|---|
| Do you have a personal history of schizophrenia or schizoaffective disorder?<br>If yes, when were you diagnosed? | Yes | No |
| Do you have a personal history of anorexia nervosa?<br>If yes, what type of treatment did you receive? | Yes | No |
| Do you have a personal history of suicide attempts?<br>If yes, when? | Yes | No |
| Have you been hospitalized for any mental health concerns within the past 1 year?<br>If yes, where? | Yes | No |
| Are you currently receiving psychiatric or psychologic treatment with a mental health professional (psychiatrist, psychologist, therapist, counselor, etc)?<br>If yes, what is the name of your mental health provider? | Yes | No |
| Do you have a personal history of bipolar disorder?<br>If yes, when were you diagnosed? | Yes | No |
| Do you have a personal history of bulimia?<br>If yes, what type of treatment did you receive? | Yes | No |
| Do you have a personal history of psychiatric hospitalizations?<br>If yes, when? | Yes | No |
| Have you ever received treatment for drug or alcohol abuse?<br>If yes, when? If yes, where? | Yes | No |
| Do you currently attend group therapy or support group?<br>If yes, what type of support group do you attend? | Yes | No |

**EXERCISE HISTORY:**

Are you able to exercise? YES NO If no, what are the barriers?

If yes, what type of exercise:
Walking Jogging Running Cycling Yoga Martial Arts Weight Lifting Swimming Other

How long do you exercise? _____Minutes How often do you exercise? _____Days per Week

**EATING PATTERNS/HABITS:**

Thinking about all meals and snacks, how many times a day do you usually eat? _____

What times do you typically eat in a typical day?_____

How many days a week do you eat out at a restaurant?

Breakfast _____days a week Brunch/Lunch _____days a week Dinner/Supper _____days a week

Have you experienced any food cravings (intense desires to eat a certain food) in the past 6 months? YES NO

Do you have a history of binge eating? (In the past 6 months, have you eaten what most people, would think was a very large amount of food in a short period of time (2 hours or less)? YES NO

Have you ever used laxatives to help control your weight? YES NO

**TYPICAL DIET:** Please fill this in as honestly as possible for a *TYPICAL* week and weekend day. Include amount consumed, way food was prepared (steamed, fried, baked, raw, etc.), and beverages.

| Meal | Weekday Day | Weekend Day |
|---|---|---|
| Breakfast | | |
| Lunch | | |
| Dinner/Supper | | |
| Snack 1 | | |
| Snack 2 | | |
| Snack 3 | | |

**RISK ASSESSMENT:**

| | | | |
|---|---|---|---|
| Do you have a personal history of diabetes mellitus? | Yes, Oral Medication | Yes, Insulin | No |
| Have you smoked or vaped within the past 1 year? | Yes-Quit Date: | No | |
| How do you function on a daily basis? (Are you able to make your own medical and financial decisions? | Independently | Partially Dependent | Totally Dependent |
| Do you have a personal history of COPD? | Yes | No | Unknown |
| Do you use oxygen on a regular basis? | Yes | No | Unknown |
| Do you have a personal history of pulmonary embolism? (blood clots in your lungs) | Yes | No | Unknown |
| Do you have a personal history of obstructive sleep apnea requiring CPAP/BiPAP? | Yes | No | Unknown |
| Do you have a personal history of gastroesophageal reflux disease (GERD) requiring medication within the past 30 days? | Yes | No | Unknown |
| Is your mobility limited most or all the time? | Yes | No | |
| Have you had a personal history of Myocardial Infarction? (Heart Attack) | Yes | No | Unknown |
| Do you have a personal history of percutaneous coronary intervention (PCI) or percutaneous transluminal coronary angioplasty (PTCA)? | Yes | No | Unknown |
| Do you have a personal history of cardiac surgery? | Yes | No | Unknown |
| Do you have a personal history of high blood pressure requiring medication? | Yes | No | Unknown |
| How many high blood pressure medications are you taking? | | | |
| Do you have a personal history of high cholesterol or hyperlipidemia? | Yes | No | Unknown |
| Do you have a personal history of deep vein thrombosis (DVT) | Yes | No | Unknown |

| | | | | |
|---|---|---|---|---|
| Do you have a personal history of venous stasis? | Yes | No | Unknown | |
| Do you have a personal history of an IVC filter? | Yes | No | Unknown | |
| When was the IVC filter placed? | Placed in anticipation of a procedure | IVC filter pre-existing | Unknown | N/A |
| Are you currently on dialysis? | Yes | No | Unknown | |
| Do you have a personal history of renal insufficiency? | Yes | No | Unknown | |
| Do you currently or have you ever used steroid/immunosuppressants for chronic conditions?<br><br>Duration of steroid use: _____<br>Date of steroid use: _____ | Yes | No | Unknown | |
| Do you use anticoagulants (blood thinners)? | Yes | No | Unknown | |
| Have you ever had surgery for obesity or foregut in the past? | Yes | No | Unknown | |

**WEIGHT LOSS MEDICATION HISTORY-** (if you have not used any weight loss medications, please skip to the next section):

| Medication | Physician | Year | Wt Lost (lbs) | Duration (months) | Reason for Stopping |
|---|---|---|---|---|---|
| Phentermine | | | | | |
| Diethylpropion | | | | | |
| Ephedrine | | | | | |
| Sibutramine | | | | | |
| Orlistat | | | | | |
| Phendimetrazine | | | | | |
| Topiramate | | | | | |
| Pindolol | | | | | |
| 5HTP & Carbidopa | | | | | |
| Spironolactone | | | | | |
| Fluoxetine & Sertraline | | | | | |
| Bupropion | | | | | |
| Zonisamide | | | | | |
| Metformin | | | | | |
| Exenatide | | | | | |
| Liraglutide | | | | | |
| Pramlintide | | | | | |
| Naltrexone & Bupropion | | | | | |
| Zonisamide & Bupropion | | | | | |
| Topiramate & Phentermine | | | | | |
| Rimonabant | | | | | |

Reason for discontinuing medication:

1. Anxiety
2. Rapid Heart Rate
3. High Blood Pressure
4. Pregnancy
5. Valvular Heart Disease
6. Mood Changes
7. Pulmonary Hypertension
8. Lack of Results
9. Cost
10. Diarrhea
11. Mood Changes
12. Dry Mouth
13. Other: (Please Specify)

**WEIGHT LOSS DIET HISTORY: List ALL diets and weight loss programs previously tried**

Complete the table below listing all food or liquid diets you have tried to lose weight. This information is very important to complete in its entirety so that you may be eligible for insurance coverage for surgery. Provided below is only a sample list of some diets.

| Name of diet: | Year: | How long were you on the diet? (months) | Number of pounds lost: | Was this under a doctor's supervision? |
|---|---|---|---|---|
| Atkins | | | | Yes No |
| Biggest Loser | | | | Yes No |
| Cabbage Soup | | | | Yes No |
| Low Calorie | | | | Yes No |
| Grapefruit | | | | Yes No |
| Jenny Craig | | | | Yes No |
| High Protein | | | | Yes No |
| Ideal Protein | | | | Yes No |
| Slim Fast | | | | Yes No |
| Low Carbohydrate | | | | Yes No |
| Weight Watchers | | | | Yes No |
| Mayo Clinic | | | | Yes No |
| Medifast | | | | Yes No |
| Optifast | | | | Yes No |
| Mediterranean | | | | Yes No |
| South Beach | | | | Yes No |
| Paleo | | | | Yes No |
| TOPS | | | | Yes No |
| Nutri-System | | | | Yes No |
| Metabolite | | | | Yes No |
| Dietician Consult | | | | Yes No |
| Hypnosis | | | | Yes No |
| Keto | | | | Yes No |
| Other (please specify) | | | | Yes No |

**EPWORTH SLEEPINESS SCALE:** Use the following scale to choose the **most appropriate number** for each situation: how likely are you to doze off or fall asleep in the following situations? Even if you have not done some of these things recently, try to think about how they might affect you.

| | | | | |
|---|---|---|---|---|
| Sitting and reading | 0 = would **never** doze | 1 = **slight chance** of dozing | 2 = **moderate chance** of dozing | 3 = **high chance** of dozing |
| Watching TV | 0 = would **never** doze | 1 = **slight chance** of dozing | 2 = **moderate chance** of dozing | 3 = **high chance** of dozing |
| Sitting, inactive in a public place (i.e. a theatre or a meeting) | 0 = would **never** doze | 1 = **slight chance** of dozing | 2 = **moderate chance** of dozing | 3 = **high chance** of dozing |
| Sitting as a passenger in a car for an hour without a break | 0 = would **never** doze | 1 = **slight chance** of dozing | 2 = **moderate chance** of dozing | 3 = **high chance** of dozing |
| Lying down to rest in the afternoon when circumstances permit | 0 = would **never** doze | 1 = **slight chance** of dozing | 2 = **moderate chance** of dozing | 3 = **high chance** of dozing |
| Sitting and talking to someone | 0 = would **never** doze | 1 = **slight chance** of dozing | 2 = **moderate chance** of dozing | 3 = **high chance** of dozing |
| Sitting quietly after a lunch without alcohol | 0 = would **never** doze | 1 = **slight chance** of dozing | 2 = **moderate chance** of dozing | 3 = **high chance** of dozing |
| In a car, while stopped for a few minutes in the traffic | 0 = would **never** doze | 1 = **slight chance** of dozing | 2 = **moderate chance** of dozing | 3 = **high chance** of dozing |

**SLEEP ASSESSMENT:**

Have you ever been told that you snore? YES NO

Have you ever been told that you stop breathing while sleeping (apnea)? YES NO

Have you ever woken up choking or gasping from sleep? YES NO

Do you feel like you feel excessively tired during the day? YES NO

Do you feel like you have disturbed or restless sleep? YES NO