Cardio Pulmonary Exercise Testing – CPET
Test Preparation

Please follow the guidelines below prior to your appointment to prepare test

Precautions:

- Cardio Pulmonary Exercise Testing can be physically demanding because it requires recording of lung, heart and mitochondrial function under exercise stress. (approximately 8 to 20 minutes pedaling on exercise bike)
- Non-Saputo patients must present a letter from their PCP stating that they are fit to do an exercise stress test, must have Dr. Saputo sign off on their CPET questionnaire and sign the CPET consent form, before we can schedule the test.
- If you have experienced claustrophobia please discuss with your physician prior to making an appointment for CPET. (You will be required to breathe through a mask covering nose and mouth while exercising)

Prerequisite for Test:

All patients must have filled out the CPET intake forms posted on www.HealthMedicineCenter.net and submitted it to HMC via fax, e-mail, or mail. Doctor Saputo will go over your provided health information and confirm that this test is safe for you to take. Once he signs off on your paperwork the test can be scheduled.

Prior to Test:

- You should not have had a significant illness or cold for at least a week (7 days) prior to the test.
- Follow your usual eating patterns for the five days prior to test.
- Do not exercise for twenty-four hours prior to the test.
- Fast for eight hours prior to test. (no food or drink; EXCEPT water)
  
*DO NOT STOP TAKING PRESCRIPTION MEDICATIONS*

Morning of Test:

- Do NOT smoke the morning of test.
- Wear tennis shoes and exercise clothing. (You will break into a sweat)
- Women should NOT wear lip-stick and should avoid nail polish.

Reporting & Consultation:

A report will be mailed/faxed or emailed to you within 3 weeks. The report will give you in-depth information about your cardiac, pulmonary, thyroid and mitochondrial function and how your body responds to exercise. If you want to discuss the results of the report with Dr. Saputo you can schedule a 15 min appointment. This appointment is not part of the test fee and will be charged and billed as a regular office visit. If you are not a patient of Dr. Saputo and you would like to continue seeing him for further consultation, you will have to schedule a new patient appointment thereafter.

The cost per test is $399.00, and is not billable to insurance. Medicare patients will have to sign a waiver to acknowledge that this test cannot be submitted to Medicare by Dr. Saputo or themselves. Patients with private insurance can ask for a copy of the superbill to submit on their own.

Health Medicine Center, 1620 Riviera Avenue, Walnut Creek, CA 94596, Phone: (925) 935-7500, Fax (925) 935-7770, www.HealthMedicineCenter.net
Cardio Pulmonary Exercise Test – Questionnaire

Please fill out the following medical history questionnaire truthfully and accurately. Doctor Saputo will use this information only to determine if this test would cause any risk to your health and therefore should not be performed at Health Medicine Center.

**PATIENT INFO**

Name: _______________________________________________ Date of Birth: ____/____/_______ Age: _____________

Primary Care Physician: ___________________________________________ Date of last physical exam: ____/____/______

Address: ________________________________________ City: ________________________ State: ______ Zip: ________

Email: __________________________________________ Phone 1: __________________ Phone 2: __________________

Emergency Contact Name: ______________________________ Relation: ________________ Phone:__________________

Referred by?____________________________________ Member of which Fitness Club:____________________________

Weight: _______ lbs       Height: _______ inches       Gender: ____F ____M

**MEDICAL HISTORY AND HEALTH QUESTIONS**

**PRESCRIPTIONS**

Please include dosage, frequency, reason for taking, when started or attach your own list

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**SUPPLEMENTS or Over-The-Counter (OTC) medications**

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**ALLERGIES**

intolerances to medications (*Example: penicillin – hives)*:

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Intolerances (foods, environment) *Example: cow’s milk – bloating*

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**PAST SURGICAL HISTORY (indicate date if known)**

- □ Prostate surgery/resection
- □ Thyroidectomy
- □ Cardiac Stents
- □ Gall Bladder
- □ Hemorhoidectomy
- □ Endoscopy
- □ Spinal Surgery
- □ Orthopedic/joints
- □ C-Section
- □ Adenoidectomy
- □ Pacemaker
- □ Appendectomy
- □ Bariatric surgery
- □ Colonoscopy
- □ Tubal Ligation
- □ Other
- □ Tonsillectomy
- □ Coronary Bypass
- □ Heart Valve
- □ Bowel/Stomach Resection
- □ Hysterectomy
- □ Hernia
- □ Bladder surgery

□ None
## Past Medical History:

<table>
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<tr>
<th>Condition</th>
<th>Yes</th>
<th>No</th>
<th>Date: ____________________________</th>
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<tbody>
<tr>
<td>Head Aches</td>
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<td>Stroke</td>
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<td>Seizures</td>
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<td>Pneumonia</td>
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<tr>
<td>Diabetes (Type 1 or Type 2)</td>
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<td>Thyroid Disease (Low or High)</td>
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<td>Glaucoma</td>
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<td>Macular Degeneration</td>
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<td>Hearing Loss</td>
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<td>High Blood Pressure</td>
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<tr>
<td>Blood Clots</td>
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<tr>
<td>□ Pulm Emboli (lung clots)</td>
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<td>□ DVT (leg clots)</td>
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<td>Heart Burn, Reflux</td>
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<tr>
<td>Stomach Ulcers</td>
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<td>Heart Disease</td>
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<tr>
<td>□ Coronary Disease</td>
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<td>□ MI/heart attacks</td>
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<td>□ Congestive Heart Failure</td>
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<td>□ Atrial Fibrillation</td>
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<td>□ Angina</td>
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<td>□ Valve Disorder</td>
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<tr>
<td>High Cholesterol</td>
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<tr>
<td>Gastrointestinal Bleeding</td>
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<td>Hepatitis (A, B, C)</td>
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<td>HIV / AIDS</td>
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<td>Chronic Wounds</td>
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<td>Cancer (type)</td>
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<td>Urinary Tract Infections</td>
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<tr>
<td>Incontinence</td>
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<td>Kidney Stones</td>
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<td>COPD (Emphysema, Bronchitis)</td>
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<td>Asthma</td>
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<td>Depression</td>
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<td>Bipolar Disorder</td>
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<td>Anxiety</td>
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<tr>
<td>Fibromyalgia</td>
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<td>Chronic Fatigue Syndrome</td>
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<td>Arthritis</td>
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<td>Gout</td>
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<td>Osteoporosis</td>
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<td>Prostate Disease</td>
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<td>Breast Disease</td>
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<td>Erectile Dysfunction</td>
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<td>Other</td>
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Health History Intake Form
**Review of Systems**  (✓ Yes or No for symptoms in past 6 months, 🔊 for symptoms TODAY)

**Constitutional/Endocrine**
- [ ] Yes □ No Fever
- [ ] Yes □ No Chills
- [ ] Yes □ No Weakness/Fatigue
- [ ] Yes □ No Weight Loss
- [ ] Yes □ No Weight Gain
- [ ] Yes □ No Insomnia
- [ ] Yes □ No Snoring
- [ ] Yes □ No Excessive thirst
- [ ] Yes □ No Excessive urination
- [ ] Yes □ No Cold or Heat intolerance

**Other:**

**HEENT**
- [ ] Yes □ No Sore Throat
- [ ] Yes □ No Stiff neck
- [ ] Yes □ No Change in your voice
- [ ] Yes □ No Sinus Drainage
- [ ] Yes □ No Sinus Headache
- [ ] Yes □ No Nose Bleeds
- [ ] Yes □ No Ear ache/drainage
- [ ] Yes □ No Hearing Loss
- [ ] Yes □ No Ringing in your ears
- [ ] Yes □ No Blurred Vision/Loss
- [ ] Yes □ No Wear glasses or contacts
- [ ] Yes □ No Itchy/watery eyes
- [ ] Yes □ No Dental problems

**Other:**

**Gastrointestinal**
- [ ] Yes □ No Nausea /Vomiting
- [ ] Yes □ No Difficulty swallowing
- [ ] Yes □ No Hemmoroids
- [ ] Yes □ No Diarrhea
- [ ] Yes □ No Constipation
- [ ] Yes □ No Bloody or Black stools
- [ ] Yes □ No Abdominal pain
- [ ] Yes □ No Heart burn/indigestion
- [ ] Yes □ No Frequent use of laxatives

**Other:**

**Urinary**
- [ ] Yes □ No Pain or burning with urination
- [ ] Yes □ No Urinary frequency (Night or Day)
- [ ] Yes □ No Blood in urine /Dark urine
- [ ] Yes □ No Incontinence
- [ ] Yes □ No Slow starting or stopping urine

**Other:**

**Genital/Sex Organs**
- [ ] Yes □ No Penile discharge
- [ ] Yes □ No Testicular lump/pain
- [ ] Yes □ No Breast Pain/discharge/lump
- [ ] Yes □ No Painful intercourse
- [ ] Yes □ No Lack of sexual desire
- [ ] Yes □ No Problems with performance

**Other:**

**FEMALE Reproductive**
- [ ] Yes □ No Hot Flashes
- [ ] Yes □ No Bleeding after menopause
- [ ] Yes □ No Excessive menstrual bleeding
- [ ] Yes □ No Unusual vaginal discharge

**Age at onset of menopause**
- [ ] Yes □ No Menstrual pain/cramps
- [ ] Yes □ No Spotting between periods

**Last pap smear:**
**Results:**
**Total Pregnancies:**
**Total live births:**
**Total miscarriages:**
**Total abortions:**
**Total C-sections:**

**Cardiac**
- [ ] Yes □ No Chest pain
- [ ] Yes □ No Palpitation
- [ ] Yes □ No Irregular heartbeat
- [ ] Yes □ No Exercise intolerance
- [ ] Yes □ No Leg swelling

**Other:**

**Respiratory**
- [ ] Yes □ No Persistent Cough
- [ ] Yes □ No Coughing up blood
- [ ] Yes □ No Shortness of breath
- [ ] Yes □ No Wheezing
- [ ] Yes □ No Can't breathe laying flat

**Other:**

**Skin**
- [ ] Yes □ No Rashes/Hives
- [ ] Yes □ No Skin discoloration
- [ ] Yes □ No Lesions/moles/warts
- [ ] Yes □ No Ulcers
- [ ] Yes □ No Itching
- [ ] Yes □ No Nail problems
- [ ] Yes □ No Unusual hair loss
- [ ] Yes □ No Easy bruising

**Other:**

**Pms**
- [ ] Yes □ No Depressed mood
- [ ] Yes □ No Suicidal thoughts/plans
- [ ] Yes □ No Agitation/irritability
- [ ] Yes □ No Insomnia
- [ ] Yes □ No Anxiety
- [ ] Yes □ No Frequent crying spells

**Other:**

**Masculoskeletal**
- [ ] Yes □ No Joint pains or stiffness
- [ ] Yes □ No Joint swelling
- [ ] Yes □ No Muscle weakness
- [ ] Yes □ No Back pain
- [ ] Yes □ No Muscle spasms/cramps
- [ ] Yes □ No Falling

**Other:**

**Neurological**
- [ ] Yes □ No Frequent Headache
- [ ] Yes □ No Seizures
- [ ] Yes □ No Syncope (passing out)
- [ ] Yes □ No Limb weakness
- [ ] Yes □ No Limb numbness
- [ ] Yes □ No Dizziness
- [ ] Yes □ No Swallowing difficulty
- [ ] Yes □ No Balance issues
- [ ] Yes □ No Tremors
- [ ] Yes □ No Rigidity

**Other:**

**Health History Intake Form**
SOCIAL HISTORY

Tobacco:  □ Yes, packs/day _____ # of yrs _____ □ No  □ Used to, # of years_____ Other Tobacco: □ Pipe □ Cigar □ Snuff □ Chew

Alcohol Use:  □ No □ Yes, # drinks/week _____ Is alcohol use a concern for you or others? □ No □ Yes, ______________________

Recreational Drug Use: □ No □ Yes, ______________________ Have you ever used needles? □ No □ Yes, how long ________________

Physical Limitations / Injuries
List any injuries or complications that may limit your performance on an exercise test: □ None □ Yes, Explain: ______________________

EXERCISE
Do you exercise regularly? □ No □ Yes, How often: ________________ What physical activities: _______________________________

How long is each exercise session:_______________ How hard do you exercise: □ Light □ Moderate □ Heavy

Have you ever experienced any of the following signs or symptoms?
Pain in neck, chest, or jaw with exercise ............ □ No □ Yes  Swollen ankles ................................................... □ No □ Yes
Shortness of breath with mild exertion................. □ No □ Yes  Abnormal heart beat or palpitations .................. □ No □ Yes
Dizziness or fainting............................................. □ No □ Yes  Calf pain with exercise that forced you to stop ...... □ No □ Yes
Loss of consciousness........................................... □ No □ Yes  Unusual fatigue or shortness of breath .............. □ No □ Yes

By signing below, I certify that to the best of my knowledge all the information I have furnished on this form is true and accurate.

Patient/Legal Guardian Signature ___________________________ Date _____ / _____ / ______

Please mail, email or fax the completed form to HMC. Scheduling cannot be done until approved and signed by Dr. Saputo.
HMC, 1620 Riviera Ave, Walnut Creek, CA 94596, P: 925-935-7500, Fax: 925-935-7770, email: hmc@healthmedicinecenter.net

THIS SECTION WILL BE COMPLETED BY DR. SAPUTO

Schedule Test: □ Yes □ No

Explain:

______________________________________________________________________________________________________________
______________________________________________________________________________________________________________
______________________________________________________________________________________________________________
______________________________________________________________________________________________________________
______________________________________________________________________________________________________________
______________________________________________________________________________________________________________
______________________________________________________________________________________________________________
______________________________________________________________________________________________________________

Leonard M. Saputo, MD ________________________________________________ Date: _____________________________
Consent Agreement

I hereby consent to voluntarily engage in exercise tests to determine my cardio-metabolic fitness. I also consent to a body composition test and the taking of samples of my exhaled air during exercise to properly measure my oxygen consumption and carbon dioxide production.

I understand that these tests do not take the place of a physical examination by a licensed physician nor can they be used to suggest that I am safe to exercise.

I understand that if I wish to stop at any time during the testing procedure, or feel that a test may be detrimental to my health, I am free to discontinue the testing procedure.

Before I undergo the test, I certify that I am in good health and have had a physical examination by a licensed medical physician within the last 12 months. Further, I hereby represent and inform the Health Medicine Center staff that I have completed the medical history questionnaire with truthful and correct responses. Consequently, I understand that it is important that I provide complete and accurate responses and recognize that my failure to do so could lead to possible injury.

I have read this form and understand the risk, and I realize that there are possibilities of injury or other complications, such as heart attack, which may occur during such a test or in the course of completing an assigned exercise program subsequent to such testing procedures.

I have been informed of the need for a physician’s approval (and a medical exam) before participation in this test if I have a medical condition and/or taking medications, or have concerns regarding my health that may prove harmful for me if I participate.

I understand the testing procedures that I will perform and I consent to participate in these tests and accept complete liability.

Patient Signature ___________________________ Date ____________

HMC Witness ___________________________ Date ____________
WAIVER FOR NON-COVERED MEDICAL SERVICES

- 94620-26 GA - Pulmonary Stress Test, complex 94620
- 93018-26 GA - Cardiovascular Stress Test, interpretation and report only
- 93015-26 GA – Cardiovascular stress test with physician supervision, with interpretation and report

Medicare patients acknowledge that the above services will not be submitted to Medicare. Private insurance companies may or may not reimburse for this service.

False Claims Act 31 USC Sec. 3729
“Any person who knowingly presents a false claim for payment is liable to the United States Government for a civil penalty of not less than $5000 and not more than $10,000 plus 3 times the amount of damages…and no proof of specific intent to defraud is required.”

Examples of Unethical or Illegal Coding:
* Coding services in a manner that makes them “covered” when they are generally “not covered” when reported correctly.
* Reporting code numbers or modifiers to increase payment when the documentation or circumstances of the actual service does not warrant it.
* Coding another condition as the principal diagnosis or reason for the service, when the majority of the patient’s treatment is for a preexisting condition that is excluded from reimbursement by the health plan involved.

I understand that the above may not be covered and agree to make payment in full at the time of service.

PATIENT SIGNATURE DATE
Note: You need to make a choice about receiving these health care items or services.

We expect that Medicare will not pay for the item(s) or service(s) that are described below. Medicare does not pay for all of your health care costs. Medicare only pays for covered items and services when Medicare rules are met. The fact that Medicare may not pay for a particular item or service does not mean that you should not receive it. There may be a good reason your doctor recommended it. Right now, in your case Medicare probably will not pay for:

- Cardio Pulmonary Exercise Testing CPET
  which includes a pulmonary stress test, cardiovascular stress test, and pulse oximetry

Because:
- Diagnosis has not been established yet
- The above services, supplies, or products are not covered for reimbursement by Medicare Law and are deemed patient choice or responsibility.

The purpose of this form is to help you make an informed choice about whether or not you want to receive these items or services, knowing that you might have to pay for them yourself. Before you make a decision about your options, you should read this entire notice carefully.

- Ask us to explain, if you don’t understand why Medicare probably won’t pay.
- Ask us how much these items or services will cost you in case you have to pay for them yourself or through other insurance.

PLEASE CHOOSE ONE OPTION, SIGN & DATE

☐ OPTION 1. YES. I WANT TO RECEIVE THESE ITEMS OR SERVICES.
I understand that Medicare will not decide whether to pay unless I receive these items or services. Please submit my claim to Medicare. I understand that you may bill me for items or services and that I may have to pay the bill while Medicare is making its decision. If Medicare does pay, you will refund to me any payments I made to you that are due to me. If Medicare denies payment, I agree to be personally and fully responsible for payment. That is, I will pay personally, either out of pocket or through any other insurance that I have. I understand I can appeal Medicare’s decision.

☐ OPTION 2. NO. I HAVE DECIDED NOT TO RECEIVE THESE ITEMS OR SERVICES.
I will not receive these items or services. I understand that you will not be able to submit a claim to Medicare and that I will not be able to appeal your opinion that Medicare won’t pay.

Print Patient’s Name
Medicare # (HICN):

Signature of patient or person acting on patient’s behalf Date:

Note: Your health information will be kept confidential. Any information that we collect about you on this form will be kept confidential in our offices. If a claim is submitted to Medicare, your health information on this form may be shared with Medicare. Your health information which Medicare sees will be kept confidential by Medicare.