DR. CLIFTON HUNT, M.D.
Sleep Clinic of Delaware

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Original Date:
Dates Revised:

NEW PATIENT INFORMATION

Name *(Last, First, M.I.):*			**Preferred Name**
Sex	**Date of Birth**	**Social Security #**	
Home Phone		**Cell Phone**	
Street Address			
City	**State**	**Zip**	
Email		**Referring Physician**	
Emergency Contact		**Emergency Contact Phone**	
Employer		**Occupation** (if applicable)	
Check any that apply	☐ Disabled ☐ Retired ☐ Student ☐ Unemployed ☐ None of these		
Work Hours	☐ Day shift ☐ Night shift ☐ Other:		
Do you drive for a living?	☐ Yes ☐ No	**Do you have a commercial driver's license?**	☐ Yes ☐ No

INSURANCE

Primary Insurance	**Phone Number**
Member ID	**Group ID**
Name of Subscriber/Relationship to Patient	

Secondary Insurance	**Phone Number**
Member ID	**Group ID**
Name of Insured/Relationship to Patient	

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MEDICAL HISTORY

Height	**Weight** (lbs)	**Weight 5 years ago** (lbs)
Current Medications		
Medication Allergies		

Please check if you have ever had any of the following conditions:	
☐ Asthma/Emphysema	☐ Head Trauma/Seizure Disorder
☐ Arrhythmias/Atrial Fibrillation	☐ Headaches/Memory Loss
☐ Cancer	☐ High Blood Pressure
☐ Congestive Heart Failure	☐ Nasal Obstruction/Allergies
☐ Coronary Artery Disease	☐ Panic/Anxiety Attacks/Depression
☐ Diabetes	☐ Restless Leg Syndrome
☐ GERD/Reflux	☐ Other:

Surgical History
☐ Tonsillectomy/Adenoidectomy
☐ Sinus Surgery
☐ Surgery for Sleep Apnea
☐ Other:

FAMILY HISTORY

	Parent	Grandparent	Sibling	Child
Sleep Apnea	☐	☐	☐	☐
Insomnia	☐	☐	☐	☐
Narcolepsy	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐
Stroke	☐	☐	☐	☐
Dementia	☐	☐	☐	☐
Cancer	☐	☐	☐	☐

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SLEEP HISTORY

Please describe your sleep problem.
How long have you had this sleep problem?
Have you been treated previously for your sleep problem? Please describe any treatment.

Have you noticed (or has anyone told you) that you:		
Stop breathing while sleeping?	☐ Yes	☐ No
Suddenly wake up gasping for breath or short of breath?	☐ Yes	☐ No
Snort yourself awake?	☐ Yes	☐ No
Wake up with a morning headache?	☐ Yes	☐ No
Grind your teeth?	☐ Yes	☐ No
Jerk your legs or feel them twitch during the night?	☐ Yes	☐ No
Are unable to move when falling asleep or immediately upon waking?	☐ Yes	☐ No
Have episodes of sudden muscular weakness?	☐ Yes	☐ No
Have weakness or inability to move with emotion such as laughing or crying?	☐ Yes	☐ No
Wake up with terrors during the night?	☐ Yes	☐ No
Act out your dreams?	☐ Yes	☐ No
Have nightmares?	☐ Yes	☐ No
Sleep walk or sleep talk?	☐ Yes	☐ No

Daytime Functioning		
Do you have a problem with severe sleepiness?	☐ Yes	☐ No
Do you often have a problem with your performance at work due to sleepiness?	☐ Yes	☐ No
Have you ever had a car accident caused by your sleepiness?	☐ Yes	☐ No
Have you ever fallen asleep driving?	☐ Yes	☐ No

How many hours of sleep do you get on an average night?	How many hours of sleep do you get on a bad night?
What time is your normal bedtime?	What time do you normally get up?
How many naps do you take during a typical week?	How long is your average nap?

How long does it take you to fall asleep on an average night?	How long does it take you to fall asleep on a bad night?
How many nights per week do you lie in bed for at least 30 minutes before falling asleep?	
How many times do you wake up during an average night?	How many times do you wake up during a bad night?

STOP-BANG SLEEP APNEA QUESTIONNAIRE

Do you SNORE loudly?	☐ Yes	☐ No
Do you often feel TIRED, fatigued, or sleepy during daytime?	☐ Yes	☐ No
Has anyone OBSERVED you stop breathing during your sleep	☐ Yes	☐ No
Do you have or are you being treated for high blood PRESSURE?	☐ Yes	☐ No
BMI over 35?	☐ Yes	☐ No
AGE over 50 years old?	☐ Yes	☐ No
NECK circumference > 15.75 inches (40cm)?	☐ Yes	☐ No
Male GENDER?	☐ Yes	☐ No

EPWORTH SLEEPINESS SCALE

How likely are you to doze off or fall asleep in the following situations? You should rate your chances of dozing off, not just feeling tired. Even if you have not experienced some of these situations recently, try to determine how they would likely affect you.

	0 = No chance of dozing	1 = Slight chance of dozing	2 = Moderate chance of dozing	3 = High chance of dozing
Sitting and reading				
Watching TV				
Sitting inactive in a public place				
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				