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Board Certified Neurologist
Board Certified Adult and Pediatric Sleep Specialist

Name: _____ Date: _____
Age: _____ Date of Birth: _____

Your primary care doctor: _____
Doctor who referred you: _____
Any other doctors you see: _____
Have you had sleep testing in the past? When? _____
Routine bed-partner? _____

Please describe your sleep problem or why the doctor sent you: _____
_____
_____

What time do you usually get to bed?
Work days / Weekdays_____/_____ Days off / Weekends_____/_____

What time do you turn off the lights and try to go to sleep?
Work days / Weekdays_____/ _____ Days off / Weekends_____/_____

How long does it usually take you to fall asleep?_____hours **_____** minutes

What time do you usually get up for the day?
Work days / Weekdays_____/_____ Days off / Weekends_____/_____

How many hours do you sleep at night (or during the day if shift work)?
Work days / Weekdays_____/_____ Days off / Weekends_____/_____

Approximately how many times do you wake up from sleep?_____

How well do you sleep away from home? Worse ( ) Same ( ) Better ( )

Have you ever taken prescription or over-the-counter sleeping pills? Yes ( ) No ( )

Do you feel worried, anxious, or nervous about getting a good night's sleep more than two times per week?
Yes ( ) No ( )

Do you feel creeping, crawling, or aching feelings in your legs? Yes ( ) No ( )

Are you able to keep your legs still while sitting or lying in bed? Yes ( ) No ( )

Do you have leg movements during sleep? Yes ( ) No ( )

Have you been told that you snore? Yes, routinely ( ) Not routinely ( ) Never ( )
When were you first told that you snored? _____years _____months

Have you awakened yourself with your own snoring? Yes ( ) No ( )

Do you awaken feeling short of breath or choking? Yes, routinely ( ) Not routinely ( ) Never ( )

Has anyone observed pauses in your breathing while you were sleeping? Yes ( ) No ( )

Is your shirt collar size ≥ 16 inches? Yes ( ) No ( )

Do you ever move about in your sleep? Yes ( ) No ( )

Have you ever felt unable to move while falling asleep or waking up? Yes ( ) No ( )

Do you fall asleep or doze when you don't intend to? No ( )
If yes, usually how many times per day? _____
How long have you been doing this? _____years _____months

Do you take planned naps during the day? No ( )
If yes, usually how many naps per week? _____
What time do you usually take them? _____
How long have you been doing this? _____years _____months

Have you had sleep-talking ( )? or sleep-walking ( )? Never( ) Childhood only ( )

Past Medical History Circle conditions you have or have had

Alzheimers	GERD	Liver disease
Arthritis/Lupus	Head Injury	Kidney disease
Asthma / COPD / lung disease	Heart attack	Migraine/headaches
Blood clots	Heart disease	Movement disorder
Blood disorder	High blood pressure	Seizure/epilepsy
Cancer (list type below)	High blood sugar/Diabetes	Stroke/TIA
Depression requiring treatment	High cholesterol/high lipids	Thyroid Problems

Other:_____

Immunizations: Most recent flu vaccine: _____ pneumonia vaccine: _____

Prior Hospitalizations and/or Surgeries and/or Sleep Studies:

Hospital	Date	Reason

Current Medications (including vitamins and Over-the Counter medicines):

Medication/Dose	How Long?	Medication/Dose	How Long?

Allergies:_____ [ ] No known drug allergies

Please circle the problems you are having now:

Awakenings from sleep (C)	Palpitations (Card)	Dizziness (N)
Fatigue (C)	Cough (Resp)	Muscle cramps (N)
Weight gain (C)	Shortness of Breath (Resp)	Muscle twitching (N)
Weight loss (C)	Head/Neck/Back Pain (M)	Tremor (N)
Congestion (ENT)	Joint Pain (M)	Anxiety (Ps)
Chest pain/pressure (Card)	Muscle Pain (M)	Depression (Ps)

Social History:

Tobacco: _____packs per day ( ) quit ( ) never smoked
Alcohol each day: Beer____oz Wine_____oz Liquor_____oz ( ) Socially ( ) Never ( ) Quit
Caffeine each day: Coffee_____oz Soda_____oz Tea_____oz ( ) None ( ) Quit
Energy drinks per day: _____oz ( ) Never ( ) Quit
Street Drugs: ( ) Occasionally ( ) Never ( ) Quit
Marital Status: ( ) Single ( ) Married ( ) Divorced ( ) Widowed
Number of Children: _____ **Ages:** _____ **Children's health problems?** _____ **Number of pregnancies:** _____
Occupation:
Education (highest grade completed):

Family History (Blood-Relatives):

Diagnosed with…	Who?
Insomnia	
Narcolepsy	
Obstructive Sleep Apnea	
Restless Legs Syndrome	
Sleepiness during the day	
Loud snoring	
Breathing pauses during sleep	
Sleep-talking or sleep-walking	

Other family medical problems:

_____

_____

_____

The Epworth Sleepiness Scale

Name: _____ Date:_____

How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired? This is an average of how you do feel if you were doing these things. Please use the most appropriate numbers:

0=would never doze
1=slight chance of dozing
2=moderate chance of dozing
3=high chance of dozing

Situation	Chance of Dozing
Sitting and reading	_____(0-3)
Watching TV	_____(0-3)
Sitting inactive in a public place (e.g. a theater or meeting)	_____(0-3)
As a passenger in a car for an hour without a break	_____(0-3)
Lying down to rest in the afternoon when circumstances permit	_____(0-3)
Sitting and talking to someone	_____(0-3)
Sitting quietly after a lunch without alcohol	_____(0-3)
In a car, while stopped for a few minutes in traffic	_____(0-3)

STOP-BANG Questionnaire

1. ***S***NORING: Do you snore loudly (louder than talking or loud enough to be heard through closed doors)?
   YES NO

2. ***T***IRED: Do you often feel tired, fatigued or sleepy during the daytime?
   YES NO

3. ***O***BSERVED: Has anyone observed you stop breathing during your sleep?
   YES NO

4. BLOOD ***P***RESSURE: Do you have or are you being treated for high blood pressure?
   YES NO

5. ***B***MI: more than 35kg/m^2? (see chart below)
   YES NO

6. ***A***GE: over 50 years old?
   YES NO

7. ***N***ECK CIRCUMFERENCE: Greater than 40cm or 17 inches?
   Yes NO

8. ***G***ENDER: Male
   YES NO

Weight (lbs)	Height																		
	4'10"	4'11"	5'0"	5'1"	5'2"	5'3"	5'4"	5'5"	5'6"	5'7"	5'8"	5'9"	5'10"	5'11"	6'0"	6'1"	6'2"	6'3"	6'4"
120	25	24	23	23	22	21	21	20	19	19	18	18	17	17	16	16	15	15	15
125	26	25	24	24	23	22	22	21	20	20	19	18	18	17	17	17	16	16	15
130	27	26	25	25	24	23	22	22	21	20	20	19	19	18	18	17	17	16	16
135	28	27	26	26	25	24	23	23	22	21	21	20	19	19	18	18	17	17	16
140	29	28	27	27	26	25	24	23	23	22	21	21	20	20	19	19	18	18	17
145	30	29	28	27	27	26	25	24	23	23	22	21	21	20	20	19	19	18	18
150	31	30	29	28	27	27	26	25	24	24	23	22	22	21	20	20	19	19	18
155	32	31	30	29	28	28	27	26	25	24	24	23	22	22	21	20	20	19	19
160	34	32	31	30	29	28	28	27	26	25	24	24	23	22	22	21	21	20	20
165	35	33	32	31	30	29	28	28	27	26	25	24	24	23	22	22	21	21	20
170	36	34	33	32	31	30	29	28	27	27	26	25	24	24	23	22	22	21	21
175	37	35	34	33	32	31	30	29	28	27	27	26	25	24	24	23	23	22	21
180	38	36	35	34	33	32	31	30	29	28	27	27	26	25	24	24	23	23	22
185	39	37	36	35	34	33	32	31	30	29	28	27	27	26	25	24	24	23	23
190	40	38	37	36	35	34	33	32	31	30	29	28	27	27	26	25	24	24	23
195	41	39	38	37	36	35	34	33	32	31	30	29	28	27	27	26	25	24	24
200	42	40	39	38	37	36	34	33	32	31	30	30	29	28	27	26	26	25	24
205	43	41	40	39	38	36	35	34	33	32	31	30	29	29	28	27	26	26	25
210	44	43	41	40	38	37	36	35	34	33	32	31	30	29	29	28	27	26	26
215	45	44	42	41	39	38	37	36	35	34	33	32	31	30	29	28	28	27	26
220	46	45	43	42	40	39	38	37	36	35	34	33	32	31	30	29	28	28	27
225	47	46	44	43	41	40	39	38	36	35	34	33	32	31	31	30	29	28	27
230	48	47	45	44	42	41	40	38	37	36	35	34	33	32	31	30	30	29	28
235	49	48	46	44	43	42	40	39	38	37	36	35	34	33	32	31	30	29	29
240	50	49	47	45	44	43	41	40	39	38	37	36	35	34	33	32	31	30	29
245	51	50	48	46	45	43	42	41	40	38	37	36	35	34	33	32	32	31	30
250	52	51	49	47	46	44	43	42	40	39	38	37	36	35	34	33	32	31	30

PATIENT DEMOGRAPHIC FORM

NAME: _____ **DOB:** _____

HOME ADDRESS: _____

CITY_____**STATE**_____**ZIP**_____

HOME#: _____ **CELL#:** _____

SS#: _____**MARITAL STATUS:** S M D W **(CIRCLE ONE) GENDER:** M F TG **(CIRCLE ONE)**

RACE: _____ **ETHNICITY**: _____

PRIMARY LANGUAGE SPOKEN: _____

E-MAIL ADDRESS: _____

PRIMARY DR (1st & last name): _____ **phone #:**_____

REFERRING DR (1st & last name):_____ **phone #:**_____

Preferred Lab for Blood work: **( )**Lab Corp **( )** Quest **( )** Doylestown Hospital/Wellness Center **( )** Other/PCP **(CHECK ONE)**

PREFERRED PHARMACIES: ***Please provide us a copy of your card***

Local:_____ Mail order: _____

Address: _____ Address: _____

Phone # _____ Phone #:_____

EMERGENCY CONTACT: _____ relationship: _____ **phone #** (different from above) _____

IF PATIENT IS UNDER 18:

MOTHER'S NAME: _____ DAYTIME PHONE: _____

FATHER'S NAME: _____ DAYTIME PHONE: _____

ADDRESS IF DIFFERENT FROM CHILD: _____

****Attention: AUTO and WORKERS COMP PATIENTS: Please complete the following information. It is needed to submit your claims. If you do not supply ALL info, your appointment will be rescheduled. Thank you.**

Date of Injury: _____

Name of Employer: _____ Phone #_____

Address of Employer: _____

Name of Insurance Company: _____Phone #_____

Address to send claim: _____

City: _____State:_____Zip_____

Claim#:_____ Contact Name: _____

Authorization to Disclose Health Information

Name: _____

DOB: _____

I,_____ hereby authorize Doylestown Health Neurology to release ALL my Protected Health Information to:

Only Myself _____

My Spouse/Significant Other (Name) _____Phone#_____

My Children (Name) _____Phone#_____

_____Phone#_____

Other (Name) _____ Relationship _____Phone#_____

_____ I give my permission to LEAVE MESSAGES ON VOICE MAIL regarding test results, answer questions, etc.

I understand that the Health Insurance Portability and Accountability Act of 1996, and its implementing regulations (HIPPA) govern the terms of this Authorization. I understand that I have the right to revoke this Authorization at any time prior to the Practice's compliance with the request set forth herein, provided that the revocation is in writing. I further understand that the additional information relating to the exceptions, to the right to revoke and a description of how I may revoke this Authorization is set forth in the Practice's Notice of Privacy Practices. I understand that any revocation must include my name, address, telephone number, date of this Authorization, and my signature and should be sent to **Doylestown Health Neurology**.

I understand that I am not required to sign this Authorization and that the Practice may not condition treatment on my execution of this Authorization.

I understand that the information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the Recipient listed above, and in that case, will no longer be protected by HIPAA.

This Authorization expires upon (cessation of treatment; conclusion of course treatment; release from the hospital)

I hereby acknowledge this Authorization

_____

Signature of Individual or Personal Representative Date

_____

Description of Personal Representative's Authority