RIVERSIDE
Neurology & Sleep Specialists
A Department of Riverside Regional Medical Center

Complaint Questionnaire

Name _____ SS# _____ Date _____

Age _____ Date of Birth _____ Marital Status _____ Home Phone _____

Occupation _____ Daytime Phone _____

Primary doctor _____ Cell Phone _____

Referred by _____ Other physician(s)? _____

Chief Complaint: Describe your main sleep problem

_____

_____

When did your problem begin? (Please check) ❒ 6 months ❒ 1 yr ❒ 2 yr ❒ 5 yr ❒ more than 5 yr
Is it getting ❒ worse ❒ better ❒ staying the same?
Does anything help? _____ Make it worse? _____
Was anything associated with its onset? _____
Do you sleep with someone? ❒ Yes ❒ No
What sleeping position(s) do you prefer (side, back, stomach)? _____

Daytime Sleepiness

	Never	Rarely	Occasionally	Frequently
Do you take intentional naps?	❒	❒	❒	❒
Do you fall asleep unintentionally when sitting quietly? (while watching TV, reading, or in a theater for example)	❒	❒	❒	❒
Do you fall asleep unintentionally such as at work?	❒	❒	❒	❒
Have you ever nodded off while driving?	❒	❒	❒	❒
<u>As a result of nodding while driving, have you</u>				
Fallen asleep at a stoplight?	❒	❒	❒	❒
Veered out of your lane or run off the road?	❒	❒	❒	❒
Been involved in an accident or near-accident?	❒	❒	❒	❒
In the <u>first 15 minutes</u> of sleep, do you have dreams that are so vivid that you can't tell if you are awake or asleep?	❒	❒	❒	❒
If you are surprised, angry, upset, or laugh, do your knees buckle and you fall to the ground?	❒	❒	❒	❒
Do you awaken and you can't move your muscles because they feel paralyzed?	❒	❒	❒	❒

Sleep Hygiene

What do you usually do during the hour before bed? _____
Do you often read in bed? ❒ Yes ❒ No Do you often watch TV in bed? ❒ Yes ❒ No
During the night, do you often look at the clock? ❒ Yes ❒ No
On average, how many **caffeinated** drinks do you consume **daily**? When is your last caffeine of the day? _____
Coffee _____ Tea _____ Soda _____
How many alcoholic beverages do you generally drink **each day**? _____
Do you smoke? ❒ Yes ❒ No How much? _____ How many years? _____
If you used to smoke; how much? _____ How many years? _____ Year you quit? _____

Sleep Pattern

Do you work shifts at night or varying times? _____
Typical bed time during the week? _____ On weekends? _____
How long does it usually take you to fall asleep? _____
How many times do you usually awaken during the night? ❒ 0 ❒1 ❒ 2 ❒ 3 ❒ 4 ❒ 5 ❒ 6 ❒ 7
How many times do you urinate during the night? ❒ 0 ❒1 ❒ 2 ❒ 3 ❒ 4 ❒ 5 ❒ 6 ❒ 7
How long does it usually take you to return to sleep? _____
What time do you usually wake up during the week? _____ On weekends? _____
Upon awakening, do you feel ❒ tired ❒ rested ❒ other? _____

Please check the box that best describes your sleep.	**Never**	**Rarely**	**Occasionally**	**Frequently**
Restless legs	❒	❒	❒	❒
Leg twitches	❒	❒	❒	❒
Leg cramps	❒	❒	❒	❒
Cold feet in bed	❒	❒	❒	❒
Morning headaches	❒	❒	❒	❒
Snore	❒	❒	❒	❒
Pause or stop breathing, gasp for breath	❒	❒	❒	❒
Dry mouth	❒	❒	❒	❒
Drool	❒	❒	❒	❒
Toss and turn	❒	❒	❒	❒
Grind teeth	❒	❒	❒	❒
Heartburn, reflux (acid taste in mouth)	❒	❒	❒	❒
Night sweats	❒	❒	❒	❒
Nightmare	❒	❒	❒	❒
Bedwetting	❒	❒	❒	❒
Sleep walking	❒	❒	❒	❒

Family History

Do you have family members who snore or have sleep problems? Which family members and what problems?

Have there been any significant illnesses (cancer, Heart disease, etc) in your family? What problem(s) and which family members?

Medical History / Hospitalizations

Reason and approximate year of hospitalizations, operations, and significant illnesses:

Have you had a tonsillectomy and / or adenoidectomy? ❒ Yes ❒ No

Medications

Please list all medications. Include all over-the-counter remedies and any you take occasionally:

Daily	**Occasionally**

Name any drugs to which you are allergic:

Height? _____ Current weight? _____ Maximum weight ever? _____

Please check the box and circle the appropriate item.

❒ **Eye problems?** Glasses or contacts, glaucoma, cataracts. Other? _____
❒ **Ear, nose or throat problems?** Hearing, congestion, soreness, swallowing. Other? _____
❒ **Hormone?** Diabetes, thyroid problems, heat or cold intolerance, hot flushes. Other? _____
❒ **Cancer?** What? _____
❒ **Respiratory, breathing problems?** Asthma, shortness of breath, cough. Other? _____
❒ **Blood pressure problems?** Since when (year)? _____
❒ **Heart?** Chest pain, skipped beats, racing heart. Other? _____
❒ **Vascular problems?** Swelling in ankles or feet, headaches. Other? _____
❒ **GI (Stomach)?** Ulcers, vomiting, bleeding, nausea, heartburn. Other? _____
❒ **Urinary problems?** Difficulty urinating, bladder infection. Other? _____
❒ **Musculoskeletal?** Aches or pains, arthritis. Other? _____
❒ **Neurological?** Fainting, dizziness, stroke, numbness, seizures, unconsciousness. Other? _____
❒ **Skin?** Rashes, itching. Other? _____
❒ **Allergies?** Pollen, dust allergies. Other? _____ (Drug allergies on previous page)
❒ **Mood / Psychological?** Sadness, down in the dumps feelings, depression, irritability, feelings of hopelessness, crying episodes, memory problems, problems with concentration, loss of usual interest, impatience, loss of appetite, inability to wait or sit still, considered suicide, made plans for suicide, suicidal attempt. Other? _____
_____
❒ **Other?** _____
_____
_____

Social History

City / State of Birth _____ Grew up where _____

Number of marriages _____ Currently for how long _____
Number of children _____

Present Occupations / job duties
_____
_____
_____

Employed by _____

Length of time in present job _____

Have you ever served in the military? ❒ Yes ❒ No If yes, what branch and for how long? _____

Is there anything else that may be important? If so, please describe. _____
_____
_____
_____
_____