(PATIENT)

South Nassau®
CENTER FOR SLEEP MEDICINE

Adolescent Sleep Disorder Questionnaire

For Children Ages 12 - 17

Instructions: Please review this form for accuracy prior to submission. You may complete this information prior to arrival at the center. This will help us provide your child's doctor with accurate study results. PLEASE USE BLACK PEN.

PATIENT NAME: _____ **DATE**_____
(Please print clearly)

Patient's Date of Birth: _____ Age:_____ ❑ Male ❑ Female

Height: _____inches Current Weight: _____ lbs. Most your son/daughter ever weighed: _____ lbs.

Parent/Guardian Name: _____

Address:_____

Daytime Phone: _____ Evening Phone: _____ Cell Phone: _____
(Area Code and Number) *(Area Code and Number)* *(Area Code and Number)*

Referring Physician:_____ Family Physician: _____

Address: _____ Address: _____

_____ _____

Phone:_____ Phone: _____
(Area Code and Number) *(Area Code and Number)*

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1. Describe your child's sleep problem: _____
   _____
   _____
2. When did your child's sleep problem begin:_____ *(Month/Year)*
3. Has your child ever had a sleep study performed?_____ ❑ YES ❑ NO
   If "yes", what were the results?_____
   _____
   _____
4. My child sleeps an average of _____ hours.
5. It usually takes my child_____ minutes to fall asleep
6. My child is difficult to awaken_____ ❑ YES ❑ NO

7. **During the week** my child

Goes to bed at _____*(time)*

Gets up at _____*(time)*

Sleeps _____*(hours)*

During the weekend my child

Goes to bed at _____*(time)*

Gets up at _____*(time)*

Sleeps _____*(hours)*

8. My child usually wakes up _____ times a night.

   Please explain what wakes your child up_____

   _____

   _____

9. My son/daughter has difficulty falling asleep due to worries?
   stress, or thoughts racing through his/her head ..... ❑ Nightly ❑ Weekly ❑ Rarely ❑ Never

10. My son/daughter snores ..... ❑ YES ❑ NO
    (If no, skip to question 13)
11. My son/daughter snores in all positions ..... ❑ YES ❑ NO

12. My son/daughter's snoring is best described as.....❑ Mild ❑ Moderate ❑ Severe

13. My son/daughter has been witnessed to stop breathing at night..... ❑ YES ❑ NO

14. My son/daughter wakes up gasping, coughing,
    or short of breath.....❑ Daily ❑ Weekly ❑ Seldom ❑ Never

15. My son/daughter wakes up with a headache.....❑ Daily ❑ Weekly ❑ Seldom ❑ Never

16. My son/daughter falls asleep at school, after school
    watching TV, sitting quietly.....❑ Daily ❑ Weekly ❑ Seldom ❑ Never

17. Teachers have reported concentration/behavior
    problems with my son/daughter in school..... ❑ YES ❑ NO

18. My son/daughter has a bed wetting problem.....❑ YES ❑ NO

19. My son/daughter falls asleep while stopped at
    red lights or while driving.....❑ YES ❑ NO

20. My son/daughter seems more tired in the ……❑ Morning ❑ Afternoon ❑ Evening

21. After a typical night's sleep, my son/daughter seems ……❑ Refreshed ❑ Fairly Rested ❑ Somewhat Tired ❑ Very Tired

22. What grade is your child enrolled in? _____

23. My son/daughter starts school at _____ o'clock
My son/daughter returns home at _____ o'clock

24. My son/daughter naps when he/she gets home from school……❑ YES ❑ NO
If "Yes," how long does he/she nap? _____ *(hours)*

25. My son/daughter has an after school job……❑ YES ❑ NO

26. My son/daughter is active in after school activities, clubs, sports, etc. ……❑ YES ❑ NO

27. My son/daughter routinely exercises……❑ YES ❑ NO
If "Yes," what type of exercise and how often?_____

28. My son/daughter has been witnessed to kick his/her legs, toss/turn while sleeping…… ❑ Nightly ❑ Weekly ❑ Rarely ❑ Never

29. My son/daughter complains of uncomfortable sensations in his/her legs before sleeping…… ❑ Nightly ❑ Weekly ❑ Rarely ❑ Never

30. My son/daughter states that he/she dreams immediately after falling asleep…… ❑ Nightly ❑ Weekly ❑ Rarely ❑ Never

31. My son/daughter states that he/she has vivid dream-like scenes upon waking up or falling asleep…… ❑ Nightly ❑ Weekly ❑ Rarely ❑ Never

32. My son/daughter feels the sensation of not being able to move when falling asleep or awakening…… ❑ Nightly ❑ Weekly ❑ Rarely ❑ Never

33. My son/daughter has had episodes of weakness in his/her legs, arms or jaw when angry, laughing, or emotional stress……. ❑ Nightly ❑ Weekly ❑ Rarely ❑ Never

34. My son/daughter has done strange things without realizing it and seems to have lost periods of time…… ❑ Nightly ❑ Weekly ❑ Rarely ❑ Never

35. My son/daughter sleepwalks…… ❑ Nightly ❑ Weekly ❑ Rarely ❑ Never

36. My son/daughter talks in his/her sleep…… ❑ Nightly ❑ Weekly ❑ Rarely ❑ Never

37. My son/daughter has been witnessed grinding his/her teeth…❑ Nightly ❑ Weekly ❑ Rarely ❑ Never

38. My son/daughter wears a mouth guard due to teeth grinding…❑ Nightly ❑ Weekly ❑ Rarely ❑ Never

39. My son/daughter eats or drinks without full awareness during the night……❑ Nightly ❑ Weekly ❑ Rarely ❑ Never

40. My son/daughter wakes up in the morning feeling bloated and having no desire to eat breakfast……❑ Nightly ❑ Weekly ❑ Rarely ❑ Never

41. My son/daughter moves while dreaming as thought attempting to carry out the dream……❑ Nightly ❑ Weekly ❑ Rarely ❑ Never

42. My son/daughter has hurt himself/herself or their bed partner during sleep……❑ Nightly ❑ Weekly ❑ Rarely ❑ Never

43. Is there a family history of sleep problems? ……❑ YES ❑ NO
If "Yes," please explain:_____

44. Do other family members snore? ……❑ YES ❑ NO
If "Yes," which family members?_____

45. My son/daughter consumes alcohol? ……❑ YES ❑ NO
If "Yes," how many ***ounces*** per day?_____
What time are these drinks consumed?_____
What type of alcohol are they consuming?_____

46. My son/daughter consumes_____ **ounces** of caffeinated beverages per day.
(how many?)
What time during the day are they consumed?_____

47. Does your son/daughter smoke cigarettes? ……❑ YES ❑ NO
If "Yes," how many cigarettes per day?_____

48. Has your son/daughter used illegal drugs in the past year?……❑ YES ❑ NO

49. Has your son/daughter been diagnosed with an eating disorder? ……❑ YES ❑ NO

50. Has your son/daughter used diet aids or steroids in the past year? ……❑ YES ❑ NO

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51. Is your son/daughter having trouble in school, either social or academic? .....❑ YES ❑ NO
If "Yes," please explain_____

52. Has your son/daughter ever been diagnosed with depression .....❑ YES ❑ NO
anxiety, ADD or ADHD?
If "Yes," when was your son/daughter diagnosed? _____ (month) _____ (year)

53. Does your son/daughter have blood pressure problems.....❑ YES ❑ NO

54. Does your son/daughter have any heart disease? .....❑ YES ❑ NO
If "Yes," please explain_____

55. Does your son/daughter have a thyroid problem? .....❑ YES ❑ NO

56. Does your son/daughter have diabetes? .....❑ YES ❑ NO

57. Does your son/daughter have asthma or lung disease..... ❑ YES ❑ NO
If "Yes," please explain_____

58. Have any of your son's/daughter's medications been discontinued by you or
his/her physician in the past 90 days? .....❑ YES ❑ NO

59. Has your son/daughter had his/her tonsils removed? .....❑ YES ❑ NO

60. Please list all medications your child is presently taking:_____
_____
_____

61. Please list any medications your child has taken for improving sleep or staying awake:_____
_____
_____

62. Please make any additional comments regarding your child's sleep problems:_____
_____
_____

63. How did you hear about the sleep center?_____
_____
_____

_____ _____ _____
(Patient) *(Parent/Guardian)* *(Date)*