(Patient)

Pediatric Sleep Disorder Questionnaire

For Children Ages 11 and Under

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: ______________ *(Area Code and Number)* Evening Phone: ______________ *(Area Code and Number)* Cell Phone: ______________ *(Area Code and Number)*

Referring Physician:__________________________

Address: ________________________________

____

Phone:__________________________________ *(Area Code and Number)*

Family Physician: ___________________________

Address: ________________________________

____

Phone: _________________________________ *(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

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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. If your child wakes up, how long does it take for him/her to fall back to sleep? _______ (minutes)

10. My child falls asleep in his/her bed .... ❑ Nightly ❑ Weekly ❑ Rarely ❑ Never

11. My child falls asleep in his/her parent's bed.......................... ❑ Nightly ❑ Weekly ❑ Rarely ❑ Never

12. My child needs a parent in his/her room to fall asleep...........❑ Nightly ❑ Weekly ❑ Rarely ❑ Never

13. My child cannot go back to sleep...❑ Nightly ❑ Weekly ❑ Rarely ❑ Never

14. My child awakens at night and stays in his/her bed.................❑ Nightly ❑ Weekly ❑ Rarely ❑ Never

    If not, to whose bed does your child go? ____

15. My child snores... ❑ YES ❑ NO
    (If no, please go to question 19)

16. My child started snoring at age ______________________________________

17. My child snores in all positions.. ❑ YES ❑ NO

18. My child's snoring is best described as ....❑ Mild ❑ Moderate ❑ Severe

19. My child has been witnessed to stop breathing at night .... ❑ YES ❑ NO

20. My child has trouble breathing through his/her nose.. ❑ YES ❑ NO
    If "Yes", please explain____
    ____

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21. My child has recurrent ear infections………………………………………………………………… ❑ YES ❑ NO
If "Yes," how often do they occur? ____

22. My child wakes up gasping for air…………………………………… ❑ Daily ❑ Weekly ❑ Rarely ❑ Never

23. My child wakes up coughing……………………………………………… ❑ Daily ❑ Weekly ❑ Rarely ❑ Never

24. My child wakes up with a headache………………………………… ❑ Daily ❑ Weekly ❑ Rarely ❑ Never

25. My child has been diagnosed with esophageal reflux………………………………………… ❑ YES ❑ NO

26. My child has been toilet trained……………………………………………………………………… ❑ YES ❑ NO
(If no skip question 27)

27. My child has a bed wetting problem……………………………………………………………… ❑ YES ❑ NO
If "Yes," how frequently does this occur ………………………………………… ❑ Daily ❑ Weekly ❑ Rarely

28. My child falls asleep at school, after school,
watching TV, in the car…………………………………………………… ❑ Daily ❑ Weekly ❑ Rarely ❑ Never

29. My child has recent mood, memory or concentration problems…………………………… ❑ YES ❑ NO
If "Yes," please explain ____
____

30. My child is hyperactive during the day………………………………………………………… ❑ YES ❑ NO

31. My child seems more tired in the……………………………………………… ❑ Morning ❑ Afternoon ❑ Evening

32. After a typical night's sleep, my child seems………………………… ❑ Refreshed ❑ Fairly rested
❑ Somewhat rested ❑ Very tired

33. My child is enrolled in………………………………………………… ❑ Pre-school ❑ Kindergarten ❑ Grade School

34. My child starts school at ____________ o'clock
My child returns home at _____________ o'clock

35. My child naps when he/she gets home from school…………………………………………… ❑ YES ❑ NO
If "Yes," how long does your child nap? ________ (hours)

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

37. My child complains of uncomfortable growing pains in his/her legs before sleeping.. ❑ Nightly ❑ Weekly ❑ Rarely ❑ Never

38. My child makes rhythmic movement such as: bangs his/her head, rocks his/her body, kicks his/her legs to initiate sleep.. ❑ Nightly ❑ Weekly ❑ Rarely ❑ Never
If "Yes", which movement...... ❑ Head Banging ❑ Rocking of Body ❑ Leg Kicking ❑ Other __________

39. My child has been witnessed grinding his/her teeth while sleeping.. ❑ Nightly ❑ Weekly ❑ Rarely ❑ Never

40. My child wears a mouth guard due to teeth grinding.............. ❑ Nightly ❑ Weekly ❑ Rarely ❑ Never

41. My child sleepwalks.. ❑ Nightly ❑ Weekly ❑ Rarely ❑ Never

42. My child wakes up screaming, does not recognize his/her surroundings and is unable to be comforted............................ ❑ Nightly ❑ Weekly ❑ Rarely ❑ Never

43. My child has nightmares.. ❑ Nightly ❑ Weekly ❑ Rarely ❑ Never

44. My child drinks ____________ caffeinated beverages per day.
(# of ounces)

45. My child exercises.. ❑ YES ❑ NO
If "Yes," what type of exercise and how often? ____
____

46. My child is breast fed.. ❑ YES ❑ NO
If "Yes," at what times? ____

47. My child has been diagnosed with ADD or ADHD.. ❑ YES ❑ NO
If "Yes," when was your child diagnosed? ____________ (month) ____________ (year)

48. My child is on medication for ADD/ADHD.. ❑ YES ❑ NO

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

50. Do other family members snore? .... ❑ YES ❑ NO
If "Yes," which family members?____
____

51. Does your child have blood pressure problems? .... ❑ YES ❑ NO

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52. Does your child have any cranio/facial abnormalities? ....❑ YES ❑ NO
(For example: Pierre Robin, Cleft lip/palate)
If "Yes," please explain ____

53. Has your child had any surgeries for the above abnormalities? ....❑ YES ❑ NO
If "Yes," what type of surgery and when was it performed____________________________________
____
____

54. Was your child born prematurely? ....❑ YES ❑ NO

55. Was your child on an apnea monitor? ....❑ YES ❑ NO

56. Did your child have any abnormalities at birth? ....❑ YES ❑ NO
If "Yes," please explain____

57. Does your child have heart disease? ....❑ YES ❑ NO
If "Yes," please explain____

58. Does your child have a thyroid problem? ....❑ YES ❑ NO

59. Does your child have diabetes? ....❑ YES ❑ NO

60. Does your child have asthma or lung disease? ....❑ YES ❑ NO
If "Yes", please explain____

61. Have any of your child's medications been discontinued by you or
his/her physician in the last 90 days? ....❑ YES ❑ NO

62. Has your child had his/her tonsils removed? ....❑ YES ❑ NO

63. Please list all medications your child is presently taking:____
____

64. Please list any medications your child has taken for improving sleep or staying awake:_______________
____
____

65. Please make any additional comments regarding your child's sleep problems:______________________
____

66. ____
How did you hear about the sleep center?____
____

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

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