Pediatric Sleep Questionnaire

Date _____

Child's Name:_____ Age _____Gender _____ DOB _____

Referring Physician: _____ Primary Care Physician: _____

Please answer fill out the following questionnaire regarding your child's sleep:

What are your major concerns about your child's sleep? _____
_____
_____
_____
What things have you done to help your child's problem? _____
_____
_____
_____

Who asked that your child be seen by a sleep specialist?
□ Pediatrician / Family Physician
□ Child's parent or Guardian
□ Surgical Specialist (e.g., ENT)
□ Pediatric Specialist (e.g., allergist, neurologist, pulmonologist)
□ Mental Health Worker (e.g., psychiatrist, psychologist, social worker)
□ School teacher, nurse, counselor
□ Child himself / herself
□ Other:_____

SLEEP HISTORY:
Weekday Sleep Schedule
Write in the amount of time the child sleeps during a 24 hour period on weekdays.
(add daytime and nighttime sleep) _____hours _____minutes
Child's usual bedtime on weekday nights _____
Child's usual wake time on weekday mornings _____

Weekend/Vacation Schedule
Write in the amount of time the child sleeps during a 24 hour period
on weekends or vacation days. (add daytime and nighttime sleep) _____hours _____minutes
Child's usual bedtime on weekday nights _____
Child's usual wake time on weekday mornings _____

Nap Schedule
Number of days each week the child takes a nap: 1 2 3 4 5 6 7
If the child naps write in the usual nap time(s)
Nap #1 **:** _____ a.m./p.m. - _____ a.m./p.m.
Nap #2 **:** _____ a.m./p.m. - _____ a.m./p.m.

SLEEP HISTORY CONTINUED:

General Sleep

Does the child have a regular bedtime routine? □ Yes □ No
Does the child have his/her own bed? □ Yes □ No
Does the child have his/her own bedroom? □ Yes □ No
Is a parent/guardian present when the child falls asleep? □ Yes □ No
Does the child listen/watch radio/TV in bed? □ Yes □ No

Child usually falls asleep in:
□ own room in own bed (alone)
□ parent's room in own bed
□ sibling's room in sibling's bed

Child sleep most of the night in:
□ own room in own bed (alone)
□ parent's room in own bed
□ sibling's room in sibling's bed

Child usually wakes in the morning in:
□ own room in own bed (alone)
□ parent's room in own bed
□ sibling's room in sibling's bed

Child is usually put in bed by:
□ Mother □ Father □ Sibling □ Self □ Other _____

Write the amount of time the child spends in his/her bedroom before going to sleep _____

Child resists going to bed? □ Yes □ No
If yes, do you think this is a problem? □ Yes □ No

Child has difficulty falling asleep? □ Yes □ No
If yes, do you think this is a problem? □ Yes □ No

Child awakens during the night? □ Yes □ No
If yes, do you think this is a problem? □ Yes □ No

After a night time awakening, child has difficulty going back asleep? □ Yes □ No
If yes, do you think this is a problem? □ Yes □ No

Child is difficult to wake in the morning? □ Yes □ No
If yes, do you think this is a problem? □ Yes □ No

Current Sleep Symptoms

□ Stops breathing during sleep
□Has difficulty breathing when asleep
□Screams out in his / her sleep
□ Kicks legs is sleep
□ Wakes up during the night
□ Gets out of bed at night
□ Trouble staying is his / her own bed
□ Resists going to bed at bedtime
□ Grinds his / her teeth
□ Uncomfortable feeling in legs; creepy-crawly feeling
□Snores
□ Restless sleep
□Sweating when sleeping
□ Wets Bed
□Poor Appetite
□Has Nightmares
□Sleep walks
□Sleep talks

SLEEP HISTORY CONTINUED:

Current Daytime Symptoms

□ Has trouble getting up in the morning
□Falls asleep at school
□Naps after school
□ Has daytime sleepiness
□Feels weak or loses muscles control with strong emotions
□Reports unable to move when falling asleep or awakening
□Sees frightening images when falling asleep or awakening

MEDICAL HISTORY:

Past Medical History

□Frequent Nasal congestion
□Sinus problems
□Allergies
□Frequent Colds or Flu
□Frequent Strep throat infections
□Acid reflux (gastro esophageal reflux)
□Excessive weight
□Speech problems
□Seizures / Epilepsy
□Cerebral palsy
□High blood pressure
□Genetic disease
□Skeleton problem (e.g., dwarfism)
□Thyroid problems
□Pain
□Meningitis
□Trouble breathing through nose
□Chronic bronchitis or cough
□Asthma
□Frequent ear infections
□Difficulty swallowing
□Poor or delayed growth
□Hearing problems
□Vision problems
□Morning headaches
□Heart disease
□Sickle cell disease
□Chromosome problem (e.g., Down's)
□Craniofacial disorder (e.g., Pierre-Robin)
□Eczema (e.g., itchy skin)
□Head / brain injury

Past Psychiatric History

□Autism
□Hyperactivity / ADHD
□Obsessive Compulsive disorder
□Suicide
□Drug use / abuse
□Psychiatric admission
□Developmental Delay
□Anxiety / Panic attacks
□Depression
□Learning disability
□Behavioral disorder

Please list any additional psychological, psychiatric, emotional, or behavioral problems diagnosed or suspected by a physician or psychologist _____
_____

Long-Term Medical Problems

If the child has long-term medical problems, please list the three you think are the most important.

1. _____
2. _____
3. _____

Surgeries / Hospitalizations

Has the child had his / her tonsils removed? □ Yes □ No
Has the child has his her adenoids removed? □ Yes □ No
Has the child ever had ear tubes? □ Yes □ No

Please list any additional hospitalizations or surgeries:
1 _____ Age:_____
2 _____ Age:_____
3 _____ Age:_____

Please list any medications child is currently taking, the dose and how often:

_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____

Allergies: _____
_____

Health Habits
Does the child drink caffeinated beverages? (e.g., Coke,Pepsi, Mountain Dew, Tea, coffee)
How many per day _____ Time of last drink_____

School Performance (if school age)
Child's grade level _____
Has child ever repeated a grade? □ Yes □ No
Is child enrolled in any special education classes? □ Yes □ No
How many school days has child missed this year? _____
How many school days did child miss last year? _____
How many school days has child been late this year? _____
How many school days was child late last year? _____
Child's grades this year: □ Excellent □ Good □ Average □ Poor □ Failing
Child's grades last year: □ Excellent □ Good □ Average □ Poor □ Failing

FAMILY SLEEP HISTORY:
Does anyone in the child's family have a sleep disorder □ Yes □ No
If Yes, mark the disorders and relationship.

Insomnia	□ Mother □ Father □ Brother/Sister □ Grandparent
Snoring	□ Mother □ Father □ Brother/Sister □ Grandparent
Sleep Apnea	□ Mother □ Father □ Brother/Sister □ Grandparent
Restless Legs Syndrome	□ Mother □ Father □ Brother/Sister □ Grandparent
Periodic Limb Movement Disorder	□ Mother □ Father □ Brother/Sister □ Grandparent
Sleep walking/sleep terrors	□ Mother □ Father □ Brother/Sister □ Grandparent
Sleep talking	□ Mother □ Father □ Brother/Sister □ Grandparent
Narcolepsy	□ Mother □ Father □ Brother/Sister □ Grandparent

Other: _____

FAMILY HISTORY:

Pregnancy / Delivery
Pregnancy: □Normal □ Difficult Delivery: □Term □ Pre-term □ Post-term
Child's Birth Weight _____lbs Only child? □Yes □No If No, circle birth order: 1st 2nd 3rd

Is there any other information you think would be helpful for the Physician to know?

_____
_____
_____
_____

Reviewed in Detail with Patient and Parent / Guardian

_____ _____

Hyong Shim, M.D. **Date**