PEDIATRIC SLEEP QUESTIONNAIRE

This set of questions is designed to help understand your child’s sleep patterns and any sleep-related problems. Please take the time to answer them and bring the questionnaire to your next appointment.

**Part 1 – Patient Information**

Male   Female

Name_________________________ Age_________________ Date of Birth_________________

Home Phone____________________ Work Phone_________________ Today’s date__________

Physicians caring for your child (family doctor, specialists, psychologist, etc.)_________________

**Part 2 – Main Complaint**

What is your child’s main sleep or alertness complaint?__________________________

How long has it occurred?_____________________________________________________

Has your child ever had a sleep study? Please indicate when and where._____________________________________________________

**Part 3 – Before Bedtime**

What does your child do before bedtime?___________________________________________

____________________________________________________________________________

Is there a set routine or does it change from day to day?______________________________

Does your child do things that could be exciting or frightening before bedtime such as watch TV, play video games or talk to friends on the phone?

____________________________________________________________________________

**Part 4 – Falling Asleep**

Where does your child usually fall asleep? Does this vary?______________________________

____________________________________________________________________________

Does your child share a bedroom?

Are there any distractions in the bedroom such as noises or lights that might affect sleep?______________________________

____________________________________________________________________________

When is bedtime?____________ How long does it take to fall asleep usually?____________

Does your child have any habits about falling asleep such as rocking or head banging?   Yes   No

**Part 5 – Sleeping**

Does your child do anything unusual or worrisome during sleep?   ____________________________

If so, please describe. ________________________________________________________________

____________________________________________________________________________
Please indicate if your child does any of the following after falling asleep.

<table>
<thead>
<tr>
<th>Talk</th>
<th>Grind teeth</th>
<th>Perspire excessively</th>
<th>Walk</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bedwetting</td>
<td>Sleep restlessly</td>
<td>Sleep in unusual positions</td>
<td>Twitch or jerk</td>
</tr>
</tbody>
</table>

**Part 6 – Nighttime Awakenings and Arousals**

Does your child have frequent nightmares? Yes No
Does your child awaken to use the toilet most nights? Yes No
Does your child get leg pains, growing pains or cramps? Yes No
Does your child awaken during the night? Yes No
If yes, how may nights weekly and how often each night? ____________________________
What usually awakens your child, if anything? ______________________________________

**Part 7 – Breathing-Related Problems**

Have you ever been worried about your child’s breathing during sleep? Yes No
Does your child snore on most nights? Yes No
If so, how loudly? ____________________________
Does your child do any of the following during sleep?
- Gasp
- Choke
- Drool
- Stop breathing
- Cough
Is your child usually a mouth breather during the day or the night? Day Night
Does your child often awaken with a dry mouth or sore throat? Yes No
Is your child comfortable sleeping on his or her back? Yes No
Does your child sleep on more than one pillow or sitting up? Yes No

**Part 8 – Morning Awakening**

What time does your child usually awaken on weekdays? ____________ Weekends ____________
How difficult is it to awaken your child? ________________________________
How late would your child like to sleep if not disturbed? ________________________________
How long after awakening, before your child is fully alert? ________________________________
Does your child frequently awaken with headaches? Yes No

**Part 9 – Daytime**

Is your child sleepy during the day? Yes No
If so, how long has this been going on? ________________________________
Does he or she take naps? Yes No
If so, when and how long? ________________________________
Does your child sleep in inappropriate times? Yes No
Does your child have episodes of unexplained pain or crying? Yes No
Does your child spit up, vomit or have heartburn? Yes No
Does your child have trouble maintaining attention? Yes No
Is your child moody or irritable? Yes No
Would you consider your child to be more than other children? Nervous Anxious Perfectionist
Does your child drink beverages with caffeine? Yes No
(Tea, coffee, cola, Mountain Dew or Dr. Pepper) if so, when and how much? ________________________________
Section 10 – Parasomnias
Does your child ever experience waking with the feeling of complete paralysis briefly?  Yes  No
Does your child have brief attacks of muscle weakness or falls for no clear reason?  Yes  No
Does your child ever hallucinate sights or sounds while falling asleep as if dreams are beginning before her she is fully asleep?  Yes  No

Part 11 – Medications
Please list all the current medications, vitamins, herbal supplements, and oxygen you child uses.
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________

Part 12 – Operations
Please list all the surgeries and what year.
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________

Part 13 – Illnesses and Injuries
Please list all the medical conditions and serious injuries.
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________

Part 14 – Allergies
Yes  No
If yes, please list them.
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________

Part 15 – Pregnancy, Labor and Delivery
During the pregnancy did mother use:
Tobacco  
Alcohol  
Medications  
Recreational Drugs
Was the child born on time?  Yes  No
What was the birth weight?  
Please note any other problems during pregnancy or delivery
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
Part 16 – Family History

Please list medical conditions in blood relatives (parents, siblings, grandparents, etc. and whom the relative is (ie: high blood pressure, stroke, heart attack, and diabetes.)

__________________________________________  __________________________________________
__________________________________________  __________________________________________
__________________________________________  __________________________________________
__________________________________________  __________________________________________
__________________________________________  __________________________________________
__________________________________________  __________________________________________

Are there any sleep-related disorders in the family?  □ Yes  □ No

Part 17 – Review of Systems

Do you have any problems relating to

□ Shortness of breath  □ Fatigue  □ Difficulty with concentration
□ Palpitations  □ Chest pain  □ Intolerance to heat or cold
□ Nose bleeds  □ Congestion  □ Abdominal distention/bloating
□ Rash  □ Headaches  □ New food allergies

Part 18 – Social History

What grade is your child in if applicable?____________________________________________________

Number of siblings___________________________________________________________

Who lives at home?____________________________________________________________

Activities outside of school and home________________________________________________

Part 19 – Addition Information

Is there anything else that you feel may be important for the physician to know about your child’s sleep and alertness problems or health?

____________________________________________________________________________________