YOUR CORNER PEDIATRICS

Sleep Questionnaire

Child's Information

Name:	Sex: Male Female Notes:
Birthdate:	Age:
Phone:	Address:
Name of Person Filling form:	Relation to Patient:

Current Concerns

1. What are your major concerns about your child's sleep?

2. When did your child's sleep problems begin?

3. What have you done to help your child's sleep problems?

4. Has your child every had a sleep study? YES / NO
    1. If yes: When, where, and what were the results?

Birth History

Delivery:	Term	Pre-Term
NICU stay?	YES	NO
Birth Weight:		
Please list any complications: (ex: ventilator, cpap, feeding tube, brain injury etc)		

Child's Sleep History

Weekday Sleep Schedule: -Bedtime: -Wake time: -# of hours sleeping in 24 hours:
Weekend Sleep Schedule: -Bedtime: -Wake time: -# of hours sleeping in 24 hours:
Nap Schedule: -How many days per week is your child napping?: -What are the usual nap times?:
Daily Sleep Habits: 1. Does your child have a regular bedtime routine? YES NO 2. Does your child have his/her own room? YES NO 3. Does your child have his/her own bed? YES NO 4. Is a parent/caregiver in the room when your child falls asleep? YES NO 5. Who usually puts the child to bed? Mother Father Both Self Other 6. How much time does your child spend in their room before they fall asleep? ____ min 7. Does your child resist going to bed? YES NO 8. Does your child have difficulty falling asleep? YES NO 9. Does your child awaken during the night? YES NO 10. After nighttime awakenings, does your child struggle to fall back asleep? YES NO 11. Is your child difficult to awaken in the morning? YES NO

Child usually falls asleep in…	Child sleeps most of the night in…	Child usually wakes up in…
Own room own bed	Own room own bed	Own room own bed
Parent's room in own bed	Parent's room in own bed	Parent's room in own bed
Parent's room parent's bed	Parent's room parent's bed	Parent's room parent's bed
Sibling's room own bed	Sibling's room own bed	Sibling's room own bed

Current Sleep Symptoms

Current Sleep Symptoms:	# of Times Occurring Per Week:				
Difficulty breathing when asleep	0	1-2	3-4	5-6	every night
Stops breathing during sleep	0	1-2	3-4	5-6	every night
Snores or noisy breathing while asleep	0	1-2	3-4	5-6	every night
Turns pale or blue during sleep	0	1-2	3-4	5-6	every night
Restless sleep/tossing and turning	0	1-2	3-4	5-6	every night
Sweating while sleeping	0	1-2	3-4	5-6	every night

Daytime sleepiness/naps after school	0	1-2	3-4	5-6	every night
Falls asleep in school	0	1-2	3-4	5-6	every night
Poor appetite	0	1-2	3-4	5-6	every night
Nightmares/Night Terrors	0	1-2	3-4	5-6	every night
Sleep talks	0	1-2	3-4	5-6	every night
Kicks or moves arms and legs during sleep	0	1-2	3-4	5-6	every night
Wets the bed	0	1-2	3-4	5-6	every night
Creepy-crawly feeling in legs/uncomfortable feelings	0	1-2	3-4	5-6	every night
Resists going to bed	0	1-2	3-4	5-6	every night
Wakes up at night	0	1-2	3-4	5-6	every night
Grinds teeth while asleep	0	1-2	3-4	5-6	every night
Trouble getting up in the morning	0	1-2	3-4	5-6	every night
Sees frightening images before falling asleep	0	1-2	3-4	5-6	every night
Feels weak or loses control of muscles suddenly with strong emotions while awake	0	1-2	3-4	5-6	every night
Screaming in sleep	0	1-2	3-4	5-6	every night

Review of Current Symptoms

General	Recurrent fevers Weight gain Weight loss/poor gain	Tiredness/fatigue Night sweats
Ears, Nose, and Throat	Runny nose Bloody nose Sinus congestions	Ear problems Eye problems Throat pain
Respiratory/Lung	Cough Coughing up blood Coughing up mucus Shortness of breath	Wheezing Noisy breathing Chest pain
Cardiovascular/Heart	Murmurs Skipping beats Fast heart beat	Poor Circulation Dizziness Passing out

Gastrointestinal	Nausea Reflux Vomiting Constipation Greasy Stools Chokes on Liquids Texture Problems	Heartburn Abdominal Pain Diarrhea Bloody Stools Gags on food Chokes on liquids Refuses Food
Endocrinology	Thyroid Low Thyroid High Metabolic Disorder	Growth Failure Steroid Problems
Neurological	Headaches Migraines	Seizures Autism
Genito-urinary	Nighttime bedwetting Frequent urination Burning on urination	Dark/bloody urine Painful urination Low back pain
Allergy/Immunology	Seasonal allergies Hives	Food allergies Immune problems
Hemo/Lymph	Bruising Bleeding	Swollen Glands
Skin	Hives Eczema Psoriasis	Hemangioma Rashes
Musculoskeletal	Muscular Dystrophy Cerebral Palsy Joint Pain	Scoliosis Back Pain

Past Medical History, Illnesses, and Surgeries

Medical History: please circle or write below	-Developmental Delay -Genetic Disorder -Autism -ADHD -Anxiety/depression -Muscular Disorder -Allergies -Sinus Issues -Difficulty Swallowing -Chronic Cough	-OCD -Behavioral Disorder -Learning Disabilities -Seizures -Neurologic Disorder -Acid reflux -Asthma -Large tonsils -Large adenoids
Surgeries: YES / NO	If yes please list:	

Medications

Previous Medications:
Allergy to Medications: YES / NO. If yes, what?
Current Medications: please name, dose, and how often taken:

School Performance

What grade is your child in?
Have you noticed a change in their performance?
Is your child falling asleep in school?
Is your child having behavior problems in school?

Family Sleep History

Does anyone in the family have a sleep disorder?	YES NO			
Insomnia	Mother	Sibling	Father	Grandparent
Restless Leg Syndrome	Mother	Sibling	Father	Grandparent
Periodic Limb Movement Disorder	Mother	Sibling	Father	Grandparent
Sleepwalking or Sleep Terrors	Mother	Sibling	Father	Grandparent
Sleepwalking	Mother	Sibling	Father	Grandparent
Narcolepsy	Mother	Sibling	Father	Grandparent
Snoring	Mother	Sibling	Father	Grandparent

Sleep Apnea	Mother Father Sibling Grandparent
Other:	Mother Father Sibling Grandparent

Epworth Sleepiness Scale

(Please place a mark in the appropriate box for each scenario)

Situation	0 Would never fall asleep	1 Slight chance of falling asleep	2 Moderate chance of falling asleep	3 High chance of falling asleep
Sitting and reading				
Sitting and watching TV or a video				
Sitting in a classroom at school in the morning				
Sitting and riding in a car or bus for 30 min				
Lying down to rest or nap in the afternoon				
Sitting and talking to someone				
Sitting quietly by yourself after lunch				
Sitting and eating a meal				

Please Complete a Sleep Diary:

(Prior to appointment is ideal, but if time does not allow it can be completed after initial appointment and sent via text)

Week 1	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY	SUNDAY
Today I drank caffeine in the:	Morning Afternoon Evening	Morning Afternoon Evening	Morning Afternoon Evening	Morning Afternoon Evening	Morning Afternoon Evening	Morning Afternoon Evening	Morning Afternoon Evening
Today I had ____ min of physical activity							
Took a nap? What time and how long?							
My mood today was:	Good OK Bad	Good OK Bad	Good OK Bad	Good OK Bad	Good OK Bad	Good OK Bad	Good OK Bad
In the 2-3 hours before bed I ate:							
In the hour before bed I did: (list activities)							
Medicine I took today and when:							
Went to bed at:							
Fell asleep at:							
Last night I woke up: **# of times** **how long**	 _____ _____	 _____ _____	 _____ _____	 _____ _____	 _____ _____	 _____ _____	 _____ _____
Reason for waking up							
In the morning I woke up at:							

Week 1	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY	SUNDAY
Last night I slept ___ hours							
In the morning I felt:	Refreshed Tired	Refreshed Tired	Refreshed Tired	Refreshed Tired	Refreshed Tired	Refreshed Tired	Refreshed Tired
Anything else relevant to mention?							

Week 2

Week 2	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY	SUNDAY
Today I drank caffeine in the:	Morning Afternoon Evening	Morning Afternoon Evening	Morning Afternoon Evening	Morning Afternoon Evening	Morning Afternoon Evening	Morning Afternoon Evening	Morning Afternoon Evening
Today I had ____ min of physical activity							
Took a nap? What time and how long?							
My mood today was:	Good OK Bad	Good OK Bad	Good OK Bad	Good OK Bad	Good OK Bad	Good OK Bad	Good OK Bad
In the 2-3 hours before bed I ate:							
In the hour before bed I did: (list activities)							
Medicine I took today and when:							
Went to bed at:							
Fell asleep at:							

Week 2	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY	SUNDAY
Last night I woke up: **# of times** **how long**	_____ _____	_____ _____	_____ _____	_____ _____	_____ _____	_____ _____	_____ _____
Reason for waking up							
In the morning I woke up at:							
Last night I slept ___ hours							
In the morning I felt:	Refreshed Tired	Refreshed Tired	Refreshed Tired	Refreshed Tired	Refreshed Tired	Refreshed Tired	Refreshed Tired
Anything else relevant to mention?							

If you have any questions about this form, please do not hesitate to call or email.
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