CHILDRENS SLEEP CENTER

PEDIATRIC SLEEP DISORDERS QUESTIONNAIRE (AGES 6-15)

Today's date: _____

Date of birth: _____ Social Security No.: _____

Name: _____

Address: _____
Street

_____
City State Zip Code

Home #: _____ Parent/Guardian Work #: _____

Sex: _____ Height: _____ Weight: _____

Was patient (circle one): Full Term Premature

If patient was premature, please indicate gestational age at birth: _____

Referring Physician: _____

Address: _____

Telephone: _____

****

Please let us know if your child has any special needs for the night of the sleep study (such as need for oxygen, if child is wheel-chair bound, requires IV pole, etc.). We will make every effort necessary to meet your child's needs and to make your stay with them as comfortable as possible.

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What is the nature of your sleeping problem?:

What makes it better or worse?

How long has this been a problem?

How serious do you believe this problem is (circle one):

Very serious Somewhat serious Not at all serious

Have you ever had a prior sleep study?

If yes, please describe the evaluation, treatment received and results:

How does the amount of sleep you get compare with others of the same age? (circle one)

More sleep About the same amount Less Sleep Not sure

What type of bedding do you sleep on?

Crib Mattress Waterbed Chair Other _____

Do others sleep in the same room with you? _____

Do others sleep in the same bed with you? _____

Do you sleep better out of the bed (for example, on the couch or floor)? _____

_____

	School Nights	Weekends
What is your normal bedtime?	_____	_____
How long does it normally take you to get to sleep?	_____	_____
How many times do you wake up during the night?	_____	_____
What wakes you up (if known)?	_____	
How long does it take you to go back to sleep after awakening?	_____	_____
What time do you normally awaken?	_____	_____
Do you awaken spontaneously, by parent, or other?	_____	
Do you stay in bed after awakening in the morning (yes or no)?	_____	_____
If so, when do you get out of bed?	_____	_____
What time do you start school?	_____	_____

How do you feel in the morning?

Alert and rested Sluggish Very groggy

How long does it take you to "get going" in the morning?

Few minutes 30 minutes An hour or more

Do you complain of any aches or pains when you wake up? No Yes

If yes, describe: _____

Grade average: A B C D F

What is your best time of day (when most alert)? _____

What is your worst time of day (when do you feel the sleepiest)?

_____

How frequently do you take naps? Describe the time of day and length of the naps:

_____

_____

How do you feel after taking a nap (circle one)?

Very refreshed Somewhat refreshed Somewhat tired Very drowsy

Do you snore (circle one)? No Yes

Has anyone ever told you that stop breathing in your sleep? No Yes

Are you a very active sleeper (example, awaken to find the sheets in disarray)? No Yes

Do you sweat excessively during the night? No Yes

Do you wake up gasping for air, choking or feeling short of breath? No Yes

Have you ever experienced loss of muscle strength (weakness in knees, sagging facial muscles or total collapse) when excited, startled, angry or laughing?

No Yes Don't know

Have you ever felt unable to move when going to sleep or waking up?

No Yes Don't know

Have you ever seen or heard things that aren't real when going to sleep or waking up?

No Yes Don't know

Do any of your family members have any of the three symptoms listed in the last three questions?

No Yes Don't know

Do you complain of unpleasant sensations in your legs at night (itching, crawling sensations)?

No Yes Don't know

If yes, describe them and what you do to relieve them: _____

Have you been told you kick your legs in your sleep? No Yes

CHECK ANY OF THE FOLLOWING YOU (the parent) HAVE NOTICED OR YOUR CHILD HAS MENTIONED:

_____Sleeping conditions too light
_____Sleeping conditions too noisy
_____Sleeping conditions too cool
_____Change in appetite
_____Change in energy level
_____Change in concentration
_____Increased tearfulness
_____Decreased interests or motivation
_____Decreased self-esteem
_____Impulsive behavior
_____Being a perfectionist
_____Increased aggressiveness
_____Irritable moods
_____Thoughts of hurting others
_____Trembling
_____Dizziness or lightheadedness
_____Dry mouth
_____Numbness or tingling
_____Feeling a "lump in throat"
_____Increased heart rate
_____Other (please describe):

_____Sleeping conditions too dark
_____Sleeping conditions too quiet
_____Sleeping conditions too warm
_____Stomach "tied in knots"
_____Nausea or vomiting
_____Increased urination (unusual for age)
_____Muscle twitching or cramps
_____Muscle tension
_____Worrying constantly
_____Checking and rechecking things

_____Unwanted thoughts
_____Rituals you MUST perform
_____Superstitious thoughts
_____Fear of germs
_____Concerns about weight
_____Concerns about appearance
_____Skipping meals/using diet pills
_____Excessive eating
_____Shortness of breath
_____Making yourself vomit after meals

How likely are you to doze off or fall asleep in the following situations? Using the following numbers, place the most appropriate response in the space.

0 = Would never fall asleep
1= Slight chance of falling sleep
2= Moderate chance of falling asleep
3= High chance of falling asleep

_____Sitting and reading
_____Watching TV or video
_____Sitting in class listening to your teacher
_____ Doing homework
_____ As a passenger in a car for an hour
_____ During a movie in a theater
_____ After meals

HAVE YOU EVER EXPERIENCED ANY OF THE FOLLOWING WHILE SLEEPING:

	Times per week	Age began	Last occurrence	Treatment (if any)
Talking				
Sleepwalking				
Grinding teeth				
Bedwetting				
Recurrent dreams				
Disturbing dreams				
Awakens screaming (during first three hours of the night):				
Complains of chest pain, wheezing, rapid or irregular heart beat:				
Waking up complaining of acid or sour taste in mouth:				
Unusual movements during sleep:				
Awakening with headaches or perspiration:				

MEDICAL HISTORY

Date of last physical examination: _____

Are you generally in good health as far as you know? _____

Has your weight changed in the last year (other than age/growth appropriate)? _____

If yes, how many pounds have you: **Gained** _____
Lost _____

List the current medication (prescribed or over the counter) you currently take:

_____

_____

List any allergies (medication or other): _____

_____

Indicate the amount and times you consume caffeinated beverages: _____

_____

Indicate the types of medical problems you have had or currently have:

Respiratory (asthma, etc) _____
Psychological _____
Diagnosed ADD/ADHD _____
Ear, nose and throat _____
Heart, circulation _____
Stomach, digestive _____
Kidney, urological _____
Head, neck, back and nervous system _____
Accidents, injuries _____
Surgeries _____
Other: _____

Please give a description of the items marked with the dates of treatment (if known): _____

_____

_____

_____