Pediatric Pulmonology Center
Pediatric Sleep Questionnaire
Peyton Manning Children's Hospital

Directions: Please answer each of the following questions by writing in or choosing the best answer. This will help us to know more about your child.

CHILD'S INFORMATION

Name:	Gender: ☐ Male ☐ Female
Birthdate:	Age:
Home Address: Home Phone: Cell/ Work:	Referring Physician: Address: Office Phone: Office Fax:

Medical History

Pregnancy/Delivery:

A. Pregnancy ☐ Normal ☐ Difficult

B. Delivery ☐ Term ☐ Pre-term ☐ Post-term

C. Child's Birth Weight:

D. Only Child? Yes No, If no circle where in birth order 1st 2nd 3rd 4th 5th 6th 7th

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

When did your child's sleep problems begin?

What have you tried to help your child's sleep problems?

Has your child ever had a sleep study? ☐ Yes ☐ No

If yes: Where was the study done: _____

When was the study done: _____

What were the results of the study: _____

PLEASE BRING A COPY OF THE SLEEP STUDIES TO THE APPOINTMENT WITH YOU.

Patient Name: _____ Date of Birth:_____

Child's Sleep History

Weekday sleep schedule:

A. Write in the amount of time your child sleeps during a 24 hour period on the **weekdays**(add daytime and nighttime hours): _____hours _____minutes

B. Childs usual **bedtime** on **weekday** nights:_____, usual **wake time** on **weekday** mornings: _____

Weekend/ Vacation Sleep Schedule:

A. Write in the amount of time your child sleeps during a 24 hour period during the **weekends and vacations** (add daytime and nighttime hours): _____ hours _____minutes.

B. Childs usual bedtime on **weekend/vacation** nights: _____.

C. Childs usual wake time **on weekend/vacation** mornings: _____.

Nap Schedule:

A. Number of days each week our child takes a nap: ☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7

B. If your child naps, write in the usual nap time(s):

Nap 1: _____ ☐ a.m. / ☐ p.m. ….. To _____ ☐ a.m. / ☐ p.m.

Nap 2: _____ ☐ a.m. / ☐ p.m. ….. To _____ ☐ a.m. / ☐ p.m.

Daily Sleep Habits:

A. Does your child have a regular bedtime routine? ☐ yes ☐ no

B.Does your child have his /her own bedroom? ☐ yes ☐ no

C. Does your child have his /her own bed? ☐ yes ☐ no

D. Is a parent present when your child falls asleep? ☐ yes ☐ no

E. Child is usually put to bed by ☐Mother ☐Father ☐ Both Parents ☐ Self ☐ other

F. How much time does your child spend in their room before they fall asleep? (_____ minutes)

G. Does your child resist going to bed? ☐ yes ☐ no

H. Does your child have difficulty falling to sleep? ☐ yes ☐ no

I. Does your child awaken during the night? ☐ yes ☐ no

J. After nighttime awakenings, does your child have difficulty falling to sleep? ☐ yes ☐ no

K. Would you consider your child a poor sleeper? ☐ yes ☐ no

L. Is your child difficult to awaken in the morning? ☐ yes ☐ no

M. If you answered yes to any of the above questions, do you think this is a problem ?
Why?

Child usually <u>falls asleep</u> in…	Child <u>sleeps most of the night</u> in…	Child usually <u>wakes in the morning</u> in..
☐ own room in owe bed(alone)	☐ own room in owe bed(alone)	☐ own room in owe bed(alone)
☐ parents' room in own bed	☐ parents' room in own bed	☐ parents' room in own bed
☐ parents' room in parents' bed	☐ parents' room in parents' bed	☐ parents' room in parents' bed
☐ sibling's room in own bed	☐ sibling's room in own bed	☐ sibling's room in own bed
☐ sibling's room in sibling's bed	☐ sibling's room in sibling's bed	☐ sibling's room in sibling's bed

Patient Name: _____ Date of Birth: _____

Current Sleep Symptoms	**Occurs times per week** (please circle)				
1. Difficulty breathing when asleep	0	1-2	3-4	5-6	every night
2. Stops breathing during sleep	0	1-2	3-4	5-6	every night
3. Snores or noisy breathing while asleep	0	1-2	3-4	5-6	every night
4. Turns pale or blue during sleep	0	1-2	3-4	5-6	every night
5. Restless sleep/ tossing and turning	0	1-2	3-4	5-6	every night
6. Sweating while sleeping	0	1-2	3-4	5-6	every night
7. Daytime sleepiness/ naps after school	0	1-2	3-4	5-6	every night
8. Falls asleep in school	0	1-2	3-4	5-6	every night
9. Poor appetite	0	1-2	3-4	5-6	every night
10. Nightmares / Night terrors	0	1-2	3-4	5-6	every night
11. Sleep talks	0	1-2	3-4	5-6	every night
12. Kick or moves arms and or legs during sleep	0	1-2	3-4	5-6	every night
13. Wets the bed	0	1-2	3-4	5-6	every night
14. Creepy-crawly feeling in legs/ uncomfortable feelings	0	1-2	3-4	5-6	every night
15. Resists going to bed	0	1-2	3-4	5-6	every night
16. Wakes up at night	0	1-2	3-4	5-6	every night
17. Gets out of bed at night	0	1-2	3-4	5-6	every night
18. Grind teeth while asleep	0	1-2	3-4	5-6	every night
19. Trouble getting up in the morning	0	1-2	3-4	5-6	every night
20. Sees sees frightening images before falling asleep	0	1-2	3-4	5-6	every night
21. Feels weak or loses contol of muscles suddenly with strong emotions while awake.	0	1-2	3-4	5-6	every night
22. Screaming in sleep	0	1-2	3-4	5-6	every night

Past Medical History (please circle)

1. Frequent nasal congestion/ Sinus problems	Yes	No	Age:
2. Trouble breathing through nose	Yes	No	Age:
3. Enlarged tonsils/ Enlarged adenoids	Yes	No	Age:
4. Chronic cough or bronchitis	Yes	No	Age:
5. Allergies	Yes	No	Age:
6. Asthma	Yes	No	Age:
7. Frequent colds or flu	Yes	No	Age:
8. Frequent strep throat	Yes	No	Age:
9. Frequent ear infections	Yes	No	Age:
10. Difficulty swallowing	Yes	No	Age:
11. Acid (Gastroesophageal) reflux	Yes	No	Age:
12. Poor or delayed growth	Yes	No	Age:
13. Excessive weight	Yes	No	Age:
14. Neurologic or muscular disorder	Yes	No	Age:
15. Cerebral Palsy	Yes	No	Age:
16. Seizure/ Epilepsy	Yes	No	Age:
17. Morning headaches	Yes	No	Age:
18. Chromosome disorder(e.g. Down's syndrome)	Yes	No	Age:
19 Skeleton problems(e.g. Dwarfism)	Yes	No	Age:
20. Genetic Disorder	Yes	No	Age:
21. Craniofacial disorder(e.g. Pierre- Robin)	Yes	No	Age:
22. Autism	Yes	No	Age:
23. Developmental delay	Yes	No	Age:
24.Hyperactivity/ ADHD	Yes	No	Age:
25.Anxiety/ Panic Attacks	Yes	No	Age:
26.Obsessive Compulsive Disorder	Yes	No	Age:
27.Depression	Yes	No	Age:
28.Sucide	Yes	No	Age:
29.Learning disabilities	Yes	No	Age:
30.Drug use/ abuse	Yes	No	Age:
31.Dehavioral disorder	Yes	No	Age:
32.Psychiatric admission	Yes	No	Age:

Patient Name: _____ Date of Birth: _____

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

Medications

Please list any medication your child is **currently taking:**

Medication Name:	**Dose:**	**How often:**

Has your child had their tonsils removed?	☐ Yes	☐ No	if yes at what age:
Has your child had their adenoids removed?	☐ Yes	☐ No	if yes at what age:
Has your child ever had ear tubes?	☐ Yes	☐ No	if yes at what age:
Has your child ever had craniofacial (head and face) surgery?	☐ Yes	☐ No	if yes at what age:

Please list any additional hospitalizations and or surgeries with dates:
Hospitalization/ surgery Date

School Performance

Current school performance (if school-aged)					
1. Have you noticed a recent change in your child's school performance?	☐ Yes	☐ No			
2. What grade is your child currently in?	☐ Yes	☐ No			
3. Has your child ever repeated a grade?	☐ Yes	☐ No	which:		
4. Is your child enrolled in any special education classes?	☐ Yes	☐ No			
5. How many school days has your child missed so far this year?					
6. How many school days did your child miss last year?					
7. How many school days has your child been tardy?					
8. How many school days last your was your child tardy?					
9. Child's grades this year?	☐Excellent	☐ Good	☐ Average	☐ Poor	☐ Failing
10. Child's grades last year?	☐Excellent	☐ Good	☐ Average	☐ Poor	☐ Failing

Family Information

Mother:	**Father:**
Age:	**Age:**
Martial Status: ☐ Married ☐ Divorced ☐ Single ☐ Separated ☐ Widowed ☐ Remarried	**Martial Status:** ☐ Married ☐ Divorced ☐ Single ☐ Separated ☐ Widowed ☐ Remarried
Education:	**Education:**
Occupation:	**Occupation:**
Work: ☐ Full-time ☐ Part-time ☐ Unemployed	**Work:** ☐ Full-time ☐ Part-time ☐ Unemployed

Persons Living in Home

Name	**Relationship**	**Age**

Family Sleep History

Does anyone in the family have a sleep disorder? If yes, please mark the disorders and family member	☐ Yes ☐ No
Insomnia (inability to fall asleep)	☐ Mother ☐ Father ☐ Brother/Sister ☐ Grandparent
Sleep Apnea	☐ Mother ☐ Father ☐ Brother/Sister ☐ Grandparent
Restless Leg Syndrome	☐ Mother ☐ Father ☐ Brother/Sister ☐ Grandparent
Periodic limb movements disorder (leg or arm moving/ jerking while sleeping)	☐ Mother ☐ Father ☐ Brother/Sister ☐ Grandparent
Sleepwalking/ sleep terrors	☐ Mother ☐ Father ☐ Brother/Sister ☐ Grandparent
Sleep talking	☐ Mother ☐ Father ☐ Brother/Sister ☐ Grandparent
Narcolepsy (inability to stay awake)	☐ Mother ☐ Father ☐ Brother/Sister ☐ Grandparent
Snoring	☐ Mother ☐ Father ☐ Brother/Sister ☐ Grandparent

Medical provider has reviewed and annotated this form. See full records for additions.

Physician Signature:_____ Date and time of evaluation: _____