



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? Yes No _____

Part 4 – Falling Asleep

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

Does your child share a bedroom? Yes No

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? Yes No

If so, please describe. _____

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

- | | | | |
|-------------------------------------|-------------------------------------------|-----------------------------------------------------|-----------------------------------------|
| <input type="checkbox"/> Talk | <input type="checkbox"/> Grind teeth | <input type="checkbox"/> Perspire excessively | <input type="checkbox"/> Walk |
| <input type="checkbox"/> Bedwetting | <input type="checkbox"/> Sleep restlessly | <input type="checkbox"/> Sleep in unusual positions | <input type="checkbox"/> Twitch or jerk |

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 many 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?
- | | | | | |
|-------------------------------|--------------------------------|--------------------------------|-----------------------------------------|--------------------------------|
| <input type="checkbox"/> Gasp | <input type="checkbox"/> Choke | <input type="checkbox"/> Drool | <input type="checkbox"/> Stop breathing | <input type="checkbox"/> 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 – Parasomias

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 relative (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

Section 17 – Review of Systems

Do you have any problems relating to?

- | | |
|----------------------------------------------------|----------------------------------------------------------------------|
| <input type="checkbox"/> Breathing while awake | <input type="checkbox"/> Frequent headaches |
| <input type="checkbox"/> Heartburn or spitting up | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Long term pain conditions | <input type="checkbox"/> Weight gain or loss over the last few years |

Section 18 – Social History

What grade is your child in if applicable? _____

Number of siblings _____

Who lives at home? _____

Activities outside of school and home _____

Section 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?
