Date
Referring Physician

PATIENT INFORMATION QUESTIONNAIRE

Please answer each of the following questions by writing in or choosing the best answer. This will help us better understand your/your child's problem related to sleep.

Child's name Gender Male **O** Female **O**

Child's current weight height Date of Birth

Person completing form Relationship to child

Your phone number home work cell

Mailing address

Email address

Check the culture that best describes your child O White/Caucasian
O Black/African-American O Asian-American O Hispanic-Latino
O Native-American O Other

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

What things have you tried to help your child's problem?

Has you child ever had surgery on their upper airway or throat?
If so, what surgery was performed at what age?
Tonsillectomy Adenoidectomy Other

Does your child drink caffeinated beverages (i.e. Pepsi, Coke, tea, Mountain Dew, coffee, energy drinks)?

O Yes O No Amount per day

Typical sleep schedule

Weekdays/School year

Usual bedtime How long to fall asleep? Usual wake time

Number of naps during day

Reports of falling asleep at school? O Yes O No

Weekends/Vacation schedule

Usual bedtime How long to fall asleep? Usual wake time

Number of naps during day

Bedtime routine

Does your child have a regular bedtime routine? O Yes O No
Is a parent present when your child falls asleep? O Yes O No

What electronic devices (TV, radio, computer, IPOD) are on at bedtime?_____
_____

Does your child awaken during the night? O Yes O No

How do you respond to nighttime awakenings? (ie child comes to parents room, child moves to another site, child is sent back to their bed, TV or music to sooth back to sleep)_____

Child usually falls asleep in:

- O alone in own bed
- O parents' room in own bed
- O parents' room in parents' bed
- O sibling's room in own bed
- O sibling's room in sibling's bed
- O other location_____

Child usually wakes in morning in:

- O alone in own bed
- O parents' room in own bed
- O parents' room in parents' bed
- O sibling's room in own bed
- O sibling's room in sibling's bed
- O other location_____

Child spends most of night in:

- O alone in own bed
- O parents' room in own bed
- O parents' room in parents' bed
- O sibling's room in own bed
- O sibling's room in sibling's bed
- O other location_____

Child resists going to bed O Yes O No If yes is this a problem? O Yes O No

Child has difficulty falling asleep? O Yes O No If yes, is this a problem? O Yes O No

Child has difficulty going back to sleep after a nighttime awakening? O Yes O No

Is your child difficult to awaken in the morning? O Yes O No

Current sleep symptoms

Circle what best describes symptom frequency:

Never = does not happen
Sometimes = 1-2 times/week
Often = 3-5 times/week
Always = 6-7 times/week

Difficulty breathing when asleep	never	sometimes	often	always
Stops breathing during sleep	never	sometimes	often	always
Snores	never	sometimes	often	always
Restless sleep	never	sometimes	often	always
Sweating during sleep	never	sometimes	often	always
Daytime sleepiness	never	sometimes	often	always
Nightmares/night terrors	never	sometimes	often	always
Sleepwalking	never	sometimes	often	always
Sleeptalking	never	sometimes	often	always
Sleeps in unusual positions	never	sometimes	often	always
Kicks legs in sleep	never	sometimes	often	always
Wakes up at night	never	sometimes	often	always
Gets out of bed at night	never	sometimes	often	always
Trouble staying in own bed	never	sometimes	often	always
Grinds teeth	never	sometimes	often	always
Wets bed	never	sometimes	often	always
Discomfort in legs	never	sometimes	often	always

Current Daytime Symptoms

Circle what best describes symptom frequency:

Never = does not happen
Sometimes = 1-2 times/week
Often = 3-5 times/week
Always = 6-7 times/week

Trouble getting up in the morning	never	sometimes	often	always	don't know
Falls asleep in school	never	sometimes	often	always	don't know
Naps after school	never	sometimes	often	always	don't know
Daytime sleepiness	never	sometimes	often	always	don't know
Feels weak or loses muscle control when laughing	never	sometimes	often	always	don't know
Morning headaches	never	sometimes	often	always	don't know
Not rested after a night's sleep	never	sometimes	often	always	don't know

Other Medical Problems

Frequent nasal congestion	O Yes O No	Poor growth	O Yes O No
Frequent throat infections	O Yes O No	Asthma	O Yes O No
Acid reflux (heartburn)	O Yes O No	Excessive weight	O Yes O No
Seizures/epilepsy	O Yes O No	Heart disease	O Yes O No
Cerebral palsy	O Yes O No	High blood pressure	O Yes O No
Diabetes	O Yes O No	Sickle cell anemia	O Yes O No
Down's Syndrome	O Yes O No	Genetic problem	O Yes O No
Skeleton problem	O Yes O No	Craniofacial disorder	O Yes O No
Thyroid problems	O Yes O No	Mouth breathing	O Yes O No

List current medications/supplements _____

_____ _____

_____ _____

_____ _____

List any medications your child has stopped taking in the last month_____

Learning/behavior/psychiatric history

Developmental delay	O Yes O No	Hyperactivity/ADHD	O Yes O No
Learning problems	O Yes O No	Behavioral disorder	O Yes O No
Depression	O Yes O No	Anxiety/panic attacks	O Yes O No
Autism	O Yes O No	Aggressive behavior	O Yes O No

Current School Performance

Does your child attend school? O Yes O No Child's current grade _____

Has your child ever repeated a grade? O Yes O No

Is your child enrolled in any special education classes? O Yes O No

Child's grades this year O Excellent O Good O Average O Poor O Failing

Child's grades last year: O Excellent O Good O Average O Poor O Failing

Family Sleep History

Does anyone in the family have a sleep disorder?

Insomnia	O Yes O No	Snoring	O Yes O No
Sleep apnea	O Yes O No	Use CPAP	O Yes O No
Restless legs Syndrome	O Yes O No	Sleepwalking	O Yes O No
Narcolepsy	O Yes O No		