Conemaugh
Memorial Medical Center

Name: ____

DOB: _______________________________

Pediatric Sleep Questionnaire

This questionnaire has been compiled from multiple sources in order to best help us assess a pediatric patient's sleep. Please fill out all questions to the best of your knowledge. This information will become part of the medical record and is considered confidential.

Demographic Information

Child's Age: __________ Gender: ❑ M ❑ F

Height: _____________ ft _____________in Weight: ______________ lbs School Grade: ____________

Parent Phone: Home: ___________________________________ Work: ___________________________________

Name of Parent / Guardian: ____

Parent's Email: ____

Physician Information

Referring Physician:

Name: ____

Address: ____

____

____

Phone: ____

Primary Care Physician (may be the same as referring):

Name: ____

Address: ____

____

____

Phone: ____

Sleep Problems

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

____

____

What have you previously tried to help this problem?: ____

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____

Sleep Times

Total estimated amount of sleep on a typical night (including naps): _______________ hours _______________ minutes

Usual bedtime: _______________ Usual wake time: _______________

Nap Schedule

Number of days each week that your child takes a nap: _______________

General Sleep Information

	Yes	No
Is there a regular bedtime routine?	❑	❑
Does the child have his / her own bedroom?	❑	❑
Does the child have his / her own bed?	❑	❑
Is there a parent present when your child falls asleep?	❑	❑
Does the child resist going to bed?	❑	❑
Does the child have difficulty falling asleep?	❑	❑
Does the child awaken during the night?	❑	❑
Is this a problem?	❑	❑
If awakening at night, does the child have difficulty returning to sleep?	❑	❑
Is the child difficult to awaken in the morning?	❑	❑
Is the child a poor sleeper?	❑	❑

Current Sleep Symptoms *(check all that apply)*

- ❑ Difficulty breathing when asleep
- ❑ Snores
- ❑ Sweating when sleeping
- ❑ Poor appetite
- ❑ Sleepwalking
- ❑ Screaming during sleep
- ❑ Waking up at night
- ❑ Trouble staying in his / her bed
- ❑ Teeth grinding
- ❑ Bedwetting
- ❑ Stops breathing during sleep
- ❑ Restless sleep
- ❑ Daytime sleepiness
- ❑ Nightmares
- ❑ Sleep talking
- ❑ Leg kicking during sleep
- ❑ Getting out of bed at night
- ❑ Resistance going to bed
- ❑ Uncomfortable “creepy-crawly” feeling in his / her legs

Current Daytime Symptoms *(check all that apply)*

- ❑ Falls asleep at school
- ❑ Daytime sleepiness
- ❑ Naps after school
- ❑ Feels weak or loses control of his / her muscles with strong emotion
- ❑ Reports being unable to move when falling asleep or upon waking
- ❑ Reports frightening visual images before falling asleep or upon waking

Family History

Does anyone in the family have a sleep disorder? ❑ Yes ❑ No

If yes, who and what disorder? ____________________

Past Behavioral Health *(check all that apply)*

- ❑ Autism
- ❑ Hyperactivity / ADHD
- ❑ Obsessive Compulsive Disorder
- ❑ Learning disabilities
- ❑ Behavioral disorder
- ❑ Developmental delay
- ❑ Anxiety / panic attacks
- ❑ Depression
- ❑ Drug use / abuse
- ❑ Psychiatric admission

Child's Medical History *(check all that apply)*

- ❑ Frequent nasal congestion
- ❑ Sinus problems
- ❑ Environmental allergies
- ❑ Frequent colds or flu
- ❑ Difficulty swallowing
- ❑ Poor or delayed growth
- ❑ Hearing problems
- ❑ Vision problems
- ❑ Morning headaches
- ❑ Heart disease
- ❑ Sickle cell disease
- ❑ Chromosome problems (e.g., Down's)
- ❑ Craniofacial disorder (e.g., Pierre-Robin)
- ❑ Eczema (itchy skin)
- ❑ Trouble breathing through his / her nose
- ❑ Chronic bronchitis or cough
- ❑ Asthma
- ❑ Frequent ear infections
- ❑ Acid reflux (gastroesophageal reflux)
- ❑ Excessive weight
- ❑ Speech problems
- ❑ Seizures / Epilepsy
- ❑ Cerebral palsy
- ❑ High blood pressure
- ❑ Genetic disease
- ❑ Skeletal problems (e.g., dwarfism)
- ❑ Thyroid problems
- ❑ Pain

Past Surgical History

Has your child ever had his / her tonsils removed? ❑ Yes ❑ No

Has your child ever had his / her adenoids removed? ❑ Yes ❑ No

Has your child ever had ear tubes? ❑ Yes ❑ No

What other surgeries has your child had (include age when surgery was performed)? ____

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Medications *(attach a separate page, if necessary)*

Name of Medication	Dose	Reason

Medication Allergies: ____

Environmental Allergies: ____