

Children/Adolescence Repeat Sleep Study Follow Up Visit

Name _____

Date _____

Person Completing this Form: _____

Relationship to Patient _____

Best Day Time Phone Number to be Reached: _____

Reason for follow up study/visit:

- | | |
|---|---|
| <input type="checkbox"/> Snoring | <input type="checkbox"/> Daytime Sleepiness _____ |
| <input type="checkbox"/> CPAP Follow up | <input type="checkbox"/> Tonsillectomy and or Adenectomy |
| <input type="checkbox"/> Weight Gain | <input type="checkbox"/> Restless Legs |
| <input type="checkbox"/> Restless Sleep | <input type="checkbox"/> Sleep Walking/Terror |
| <input type="checkbox"/> R/O Narcolepsy | <input type="checkbox"/> Difficulty Initiating/ Maintaining Sleep |
| <input type="checkbox"/> Others: (please specify) _____ | |

Does your child continue to:

<input type="checkbox"/> Snore:	<input type="checkbox"/> Improved	<input type="checkbox"/> Worse	<input type="checkbox"/> Same
<input type="checkbox"/> Feel sleepy:	<input type="checkbox"/> Improved	<input type="checkbox"/> Worse	<input type="checkbox"/> Same
<input type="checkbox"/> Have restless sleep:	<input type="checkbox"/> Improved	<input type="checkbox"/> Worse	<input type="checkbox"/> Same
<input type="checkbox"/> Wake up at night:	<input type="checkbox"/> Improved	<input type="checkbox"/> Worse	<input type="checkbox"/> Same
<input type="checkbox"/> Have trouble initiating sleep:	<input type="checkbox"/> Improved	<input type="checkbox"/> Worse	<input type="checkbox"/> Same
<input type="checkbox"/> Have trouble maintaining sleep:	<input type="checkbox"/> Improved	<input type="checkbox"/> Worse	<input type="checkbox"/> Same

During sleep does your child experience any of the following:

- | | | |
|--|--|---|
| <input type="checkbox"/> Mouth Breathing | <input type="checkbox"/> Struggle to Breathe | <input type="checkbox"/> Nasal / Chest Congestion |
| <input type="checkbox"/> Coughing | <input type="checkbox"/> Stops Breathing | <input type="checkbox"/> Other: _____ |

Review of Systems:

- | | | |
|--------------------------------------|---|---------------------------------------|
| <input type="checkbox"/> Heartburn | <input type="checkbox"/> Hyperactivity | <input type="checkbox"/> Cough |
| <input type="checkbox"/> Stomach | <input type="checkbox"/> Shortness of Breathe | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Weight Loss | <input type="checkbox"/> Weight Gain | |

Any current medical problems?

Any current medications / Inhaler / Nasal Sprays?

Any changes in health or medications since the last visit?
