



Mid-Michigan Sleep Center

PEDIATRIC SLEEP QUESTIONNAIRE

Date: _____

Patient's Name: _____ Date of Birth: _____

Age _____ Height: _____ Weight: _____ Sex: M F

Questionnaire filled by: _____ Relation to Patient _____

Your Phone Number : () _____

Name of Referring Physician(s): _____ Phone: _____

_____ Phone: _____

Any Current Medical Problem? 1- _____ 2- _____

3- _____ 4- _____

Past Medical History: 1- _____ 2- _____

Previous Surgery(s): _____

<u>Medicine/Inhaler</u>	<u>How Often</u>	<u>Last Taken</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

Allergy to medicine : _____ Seasonal Allergy _____

<u>Family History</u>	<u>Patient</u>	<u>How Long</u>	<u>Others</u>
Obstructive Sleep Apnea	_____	_____	_____
Sleep Walking	_____	_____	_____
Sleep Terror	_____	_____	_____
Nightmare	_____	_____	_____
Bed Wetting	_____	_____	_____
Narcolepsy	_____	_____	_____
Seizure	_____	_____	_____

Any history of weight change?

Gain Loss How much? _____ Over How Long? _____

Reason for referral:

At what age was this started: _____

A) Preparation For Sleep:

What is the usual supper time ? _____

What Does Your child do from supper time till he/she to bed? _____

Where does he/she fall asleep usually? (His/Her bed, Sofa, parents' bed ,etc.)

B) Sleep History :

How long will it take to fall asleep? _____

Usual bedtime: Weekday _____ Weekend _____

Usual wake up time: Weekday _____ Weekend _____

Is it hard to wake him/her up in the morning?

Weekday _____ Weekend _____

Does he/she feel sleepy or tired in the morning?

Weekday _____ Weekend _____

Usual hours of sleep: Weekday _____ Weekend _____

Does he/she wake up at night? Yes No

If yes, how often: _____ Reason: _____

During sleep, does this patient:

Snore? _____ Loudly? _____ Snore throughout the night? _____

How long? _____ Disturbing to others? _____

Gasp for air? _____ Sleep with mouth open? _____

Stop breathing? _____ Have restless sleep? _____

Look pale or blue? _____ Sound congested or stuffed? _____

Become sweaty? _____ Mouth breather? _____

Make a snorting sound and wake him/herself from sleep? _____

Any abnormal movement during sleep? _____

Have "growing pains" (unexplained leg pain)? _____

Have "growing pains" that are worse at night? _____

Kick with his/her legs briefly while asleep? _____

Grind his/her teeth at night? Yes No

C) **Daytime Behavior and other Possible Problems:**

Breathe through mouth _____ Wake up with headache in a.m. _____

Take a nap: _____ How long? _____ When? _____

Hyperactivity/Inattention:

1. Difficulty sustaining attention, starts something new before finishing task.
 Rarely Sometimes Often Always
2. Does not seem to follow through with instructions and fails to finish school work or other duties, chores, etc.
 Rarely Sometimes Often Always
3. Runs about or climbs excessively in situations where it is inappropriate.
 Rarely Sometimes Often Always

Teacher Observation

Hyperactivity? _____

Short attention span? _____

Napping? _____

Falling grades? _____

D) **Excessive Daytime Sleepiness:**

Has he/she felt an irresistible urge to take a nap at an odd time, forcing him/her to stop what he/she is doing in order to sleep? _____

If so, at what age did this develop? _____

Does your child have any sleepiness during the day? _____

If yes, what time of the day? _____

Has he/she ever found themselves awake in bed able to look around, but unable to move for a short period? _____

Has he/she ever become suddenly weak in the legs or anywhere else after laughing, being angry, or being surprised by something? _____

Has he/she ever sensed that he/she was dreaming (seeing images or hearing sounds) while still awake? _____

Others:

Does he/she drink caffeinated beverages (coffee, tea, cola) on a typical day? _____

How many cups or cans per day? _____ When? _____

Any smoking? _____ Drug abuse? _____ Alcohol abuse? _____

E) Bed Wetting:

(Answer these questions ONLY if your child is bed wetting and over 5 years of age.)

	<u>Yes</u>	<u>No</u>
Frequent Urination	___	___
Pain in urination	___	___
History of bladder infection	___	___
Allergy	___	___
Seizure	___	___
Bed wetting since birth	___	___
If no, what age restarted _____		
Bed wetting during the day	___	___
Bed wetting during the night	___	___
Back problems (spina bifida)	___	___
Family history of bed wetting	___	___
Any history of sleep problems : (<i>please Circle</i>)	Sleep Walking Sleep Terrors	Nightmares Snoring

F) Depression/Insomnia:

	<u>Yes</u>	<u>No</u>
Difficulty initiating sleep	___	___
Waking up frequently from sleep?	___	___
Waking up early in the AM?	___	___
Feeling fatigue during the day?	___	___
Inability to concentrate or remember things? <input type="checkbox"/> Rarely <input type="checkbox"/> Sometimes <input type="checkbox"/> Often <input type="checkbox"/> Always		
Decreased or loss of appetite? <input type="checkbox"/> Rarely <input type="checkbox"/> Sometimes <input type="checkbox"/> Often <input type="checkbox"/> Always		
Feels depressed, sad, or irritable? <input type="checkbox"/> Rarely <input type="checkbox"/> Sometimes <input type="checkbox"/> Often <input type="checkbox"/> Always		
Feelings of guilt, hopelessness? <input type="checkbox"/> Rarely <input type="checkbox"/> Sometimes <input type="checkbox"/> Often <input type="checkbox"/> Always		

G) Other Comments:
