ALASK SLEEP CLINIC PEDIATRIC SLEEP HISTORY QUESTIONNAIRE

Name _____ MRN _____ Date _____

Age _____ Date of Birth _____ Male / Female (circle) Height _____ Weight _____

Racial/Ethnic Background _____

Home Address:
_____
_____
_____

Telephone
Home: _____
Work: _____
Cell: _____

ASC specific questions?

Who is your childs pediatrician? _____

Who referred your child for a Sleep Medicine evaluation? _____

Is your child seen by a medical specialists, such as a Pulmonologist, Allergist or Neurologist? _____

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

_____

_____

What have you tried to help your child's sleep problem, including medications?

_____

_____

Sleep History

Does your child go to bed and wake up at the same times most days? **Yes** **No**

	Weekdays	Weekends
What time does your child go to bed?		
What time is lights out?		
What time does your child get up in the morning?		
How many hours of sleep does your child get each night?		
How many hours does he/she nap per day?		

Current Sleep Symptoms

How often does your child have the following:	Never	Sometimes (1-2 nights per week)	Routinely (3-5 nights per week)	Always (6-7 nights per week)	I do not know
Snoring					
Stop breathing when sleeping					
Choking/gasping in sleep					
Mouth breathing during the day					
Night Sweating					
Morning headaches					
Dry mouth					
Restless sleep					
Resists going to bed at bedtime					
Difficulty falling asleep? What is the average time to fall asleep?					
Trouble staying in his/her own bed					
Wakes up during the night					
Difficultly falling back asleep after a nighttime awakening					

Current Daytime Symptoms

Does your child…	Never	Sometimes (1-2 nights per week)	Routinely (3-5 nights per week)	Always (6-7 nights per week)	I do not know
Have trouble getting up in the morning					
Fall asleep at school					
Fall asleep unintentionally					
Nap after school					
Have daytime sleepiness					
Have hyperactivity					

Movement

Does your child complain of an uncomfortable feeling in his/her legs (creepy-crawly feeling) at night? **Yes No**

Does your child kick his/her legs during sleep? **Yes No**

Does your child have rhythmic or body rocking movements before falling asleep? **Yes No**

Does your child ever shake or have seizures during sleep? **Yes No**

Parasomnias / Other

Does your child currently have nightmares or night terrors? **Yes No**

Does your child grind or clench his/her teeth at night? **Yes No**

Does your child frequently wet the bed? **Yes No**

Does your child walk in his/her sleep? **Yes No**

Does your child talk in his/her sleep? **Yes No**

Has your child ever reported sudden muscle weakness or lose control of his/her muscles with strong emotions? **Yes No**

Does your child report inability to move when falling asleep or waking up? **Yes No**

Does your child report vivid dreams just before falling asleep or waking up? **Yes No**

Medical and Surgical History

Was your child born prematurely? **Yes / No** If yes, how many weeks? _____

Does your child have any allergies to food or medications? _____

Mark any of the following disorders that your child has been diagnosed with (active problem or cured)		
	Yes	No
Obstructive Sleep Apnea		
Frequent nasal congestion		
Trouble breathing through nose		
Sinus problems		
Chronic bronchitis		
Allergies		
Asthma		
Frequent ear infections		
Reflux disease		
Poor or delayed growth		
Obesity		
Hearing problems		
Speech problems		
Vision problems		
Seizures/Epilepsy		
Cerebral palsy		
Heart disease		
High blood pressure		
Genetic disease		
Head/brain injury		

Write any other medical problems your child has that are not listed:

_____

_____

_____

_____

Please list any medications that your child is currently taking, including prescriptions, over the counter medications, and herbal medications:

_____

_____

_____

_____

_____

_____

List <u>ANY</u> surgery your child has ever had, including the year the surgery was performed:

_____

_____

_____

_____

<u>Past Psychological History</u>

Mark any of the following disorders that your child has been diagnosed with (active problem or cured)		
	Yes	No
Autism		
Developmental Delay		
Hyperactivity/ADHD		
Anxiety		
Obsessive Compulsive Disorder		
Depression		
Learning disability		
Drug use/abuse		
Behavioral Disorder		
Psychiatric admission		

Write any other psychiatric problems your child has that are not listed above:

_____

_____

_____

<u>Social History</u>

Does your child drink alcohol? **Yes** **No**
If yes, how many drinks per day? _____
Does your child smoke cigarettes? **Yes** **No**
On average, how many packs per day? _____
For how many years? _____
Does your child drink caffeinated beverages? **Yes** **No**
If yes, how many drinks per day? _____
Does your child use illicit drugs? **Yes** **No**
If yes, please list _____

<u>Environmental / Bedroom History</u>

Does your child use any electronic device in bed? **Yes** **No**
(TV, cellphone, iPad, DVD player, e-book, etc.)

Does your child play music or talk on the phone in bed? **Yes** **No**

Does your child sleep in bed with pets? **Yes** **No**

Family History

Is there a history of crib death (SIDS) in your family? **Yes No**

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

If yes, mark the disorders and relationship	Mother	Father	Brother/sister	Grandparent
Insomnia				
Snoring				
Sleep Apnea				
Restless Legs Syndrome				
Sleep walking				
Narcolepsy				
Other:_____				

School Performance

Child's grade:		
	Yes	No
Has your child ever repeated a grade?		
Is your child enrolled in special education classes?		
How many school days has your child missed this year:		
What have your child's grades been this year?		
What were your child's grades last year?		

Please write any other comments about your child's sleep that was not already covered:

_____

_____

_____

_____

_____

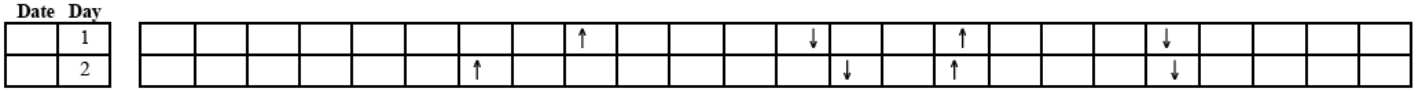
_____

Please record your child's sleep patterns for 14-days prior to your appointment with the Alaska Sleep Clinic.

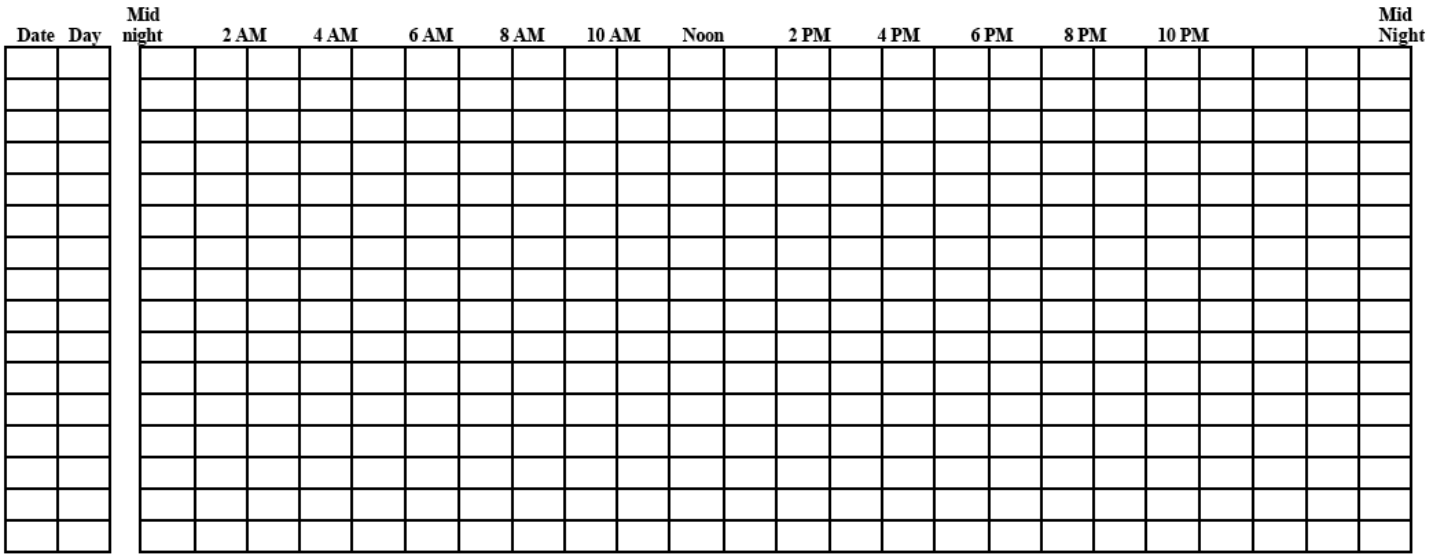
PEDIATRIC SLEEP LOG

Your name: _____

Example: **Shade in the periods when you were asleep** ↓ **Mark your bedtime and any nap times with downward arrows.** ↓



↑ **Mark the time you get up in the morning** ↑
and after any naps with upward arrows.



Your child's history is important to us in properly assessing your child's sleeping problem.