

THE SLEEP DISORDERS CENTER OF CENTRAL TEXAS

102 Westlake Drive
Suite 102
Austin, Texas 78746
(512) 329-9296

CONFIDENTIAL PEDIATRIC PATIENT QUESTIONNAIRE

Name of Patient: _____ Date: _____ Date of Birth: _____

Name of Person Completing Questionnaire: _____ Relationship: _____

Referral Source: _____

PLEASE DO NOT WRITE ON THIS SIDE OF THE PAGE

What is your primary concern regarding your child's sleep?

How long has your child had this problem? _____ # of months/years

Not including your child's primary care physician or referring doctor, has your child seen another doctor for your sleep problem? Yes No

If yes, who was the doctor and when was your child seen?

If yes, what was the diagnosis? _____

Did your child have a sleep study? Yes No

If yes, when and where? _____

What treatment, if any, was recommended? _____

Was the treatment effective? Yes No

Does your child have any allergies or reactions to drugs? Yes No

If yes, specify drug and reaction: _____

Previous PSG?
Y N

Medical History

Check the appropriate boxes if your child has or has had any of the following conditions:

- | | |
|--|---|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> High blood pressure |
| <input type="checkbox"/> Anemia/blood disease | <input type="checkbox"/> High cholesterol/triglycerides |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Kidney/bladder disease |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Learning disorder |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Liver disease |
| <input type="checkbox"/> ADHD or ADD | <input type="checkbox"/> Neurologic disease |
| <input type="checkbox"/> Other behavioral problem | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Sinusitis |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Thyroid disease |
| <input type="checkbox"/> Developmental delay | <input type="checkbox"/> Other |
| <input type="checkbox"/> Diabetes (Type I/II) | _____ |
| <input type="checkbox"/> Other Lung Disease | _____ |
| <input type="checkbox"/> Ulcers/intestinal disease | _____ |
| <input type="checkbox"/> Heartburn/acid reflux | |
| <input type="checkbox"/> Heart disease | |

Has your child had his/her tonsils removed? Yes; At what age? ____ No

Has your child had nose or throat surgery? Yes; At what age? ____ No

Please list any other surgeries and/or hospitalizations your child has had:

Date	Reason
_____	_____
_____	_____
_____	_____

(If more spaces is needed, please continue on the back of this page)

Family History

Medical N Y

Check the appropriate boxes if your child's family members have had any of the following conditions:

	Father	Mother	Siblings	Children
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Insomnia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Narcolepsy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Restless legs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sleep apnea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Snoring	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Sleep N Y

Social History

Child lives with: both parents mother father other (please explain)

Siblings (with ages):

Home address:

Where does your child sleep?

Grade level in school: _____ Special education? Yes No

Report card grades in school: _____

Tobacco

Is the child exposed to cigarette smoke? Yes No/never No/stopped

Where and by whom? _____

Caffeine

Does your child drink caffeinated beverages? Yes No

If yes, _____ # of cans of soft drinks daily

_____ # of cups/glasses of cocoa/chocolate milk

_____ # of cups/glasses of tea daily

_____ # of cups of coffee daily

Child's current weight: _____

Height: _____

Weight Status

Does your child get exercise:

at school? If yes, # of hours per week: _____

at home? If yes, # of hours per week: _____ Please describe activities:

Other: _____

Mood

Do you think your child is depressed? Yes No

Would you describe your child as a worrier?

If yes, rarely occasionally frequently

Would you describe your child as irritable?

If yes, rarely occasionally frequently

Do you feel your child has had a recent personality change? Yes No

If yes, specify: _____

Sleep Hygiene

On school days:

Bedtime: _____ a.m./p.m. Wake time: _____ a.m./p.m.

On weekend/days off:

Bedtime: _____ a.m./p.m. Wake time: _____ a.m./p.m.

Scheduled naps: Yes No

If yes, list nap times and duration. _____

Are these naps refreshing? Yes No

Are any of your naps involuntary? Yes No

If yes, when do they occur?: _____

Does your child refuse to go to bed? Yes No

Does your child have any of the following items in his/her bedroom?

TV video games computer phone

Do your child share his/her bedroom with another person and/or pet(s)?

Yes No If yes, please specify: _____

Insomnia

Does your child have difficulty falling asleep? Yes No

If yes, how long does it take? _____ # minutes/hours _____ # of nights weekly

How many times does your child awaken during the night?

_____ # of times nightly _____ # of nights weekly

Why does your child awaken? _____

Returns to sleep quickly? Yes No

Does your child have extended periods of wakefulness during the night?

Yes No If yes, _____ # minutes/hours _____ # of nights weekly

Does your child awaken too early in the morning and stay awake? Yes No

If yes, at what time _____ a.m. _____ # of times weekly

Some of the following questions will ask you to rate the frequency of certain symptoms. If you check yes to any of the boxes, please use the scale below as a guide when answering the questions.

Parasomnias

Does your child currently:

Have intense nightmares or night terrors? Yes No

If yes, rarely occasionally frequently

Grind or clench teeth at night? Yes No

If yes, rarely occasionally frequently

Talk during sleep? Yes No

If yes, rarely occasionally frequently

Walk during sleep? Yes No

If yes, with or without eating;

rarely occasionally frequently

Wet the bed during sleep? Yes No

If yes, rarely occasionally frequently

Please describe any unusual behaviors during sleep.

Hypersomnia

Sleep Prl

Cpxy

Hh

RO - Nar/MSLT

Has your child ever been injured because of falling asleep during the day?

Yes No If yes, when and describe _____

Please circle the most accurate answer for the following questions:

How often does your child fall asleep or get drowsy during class?

0 = never 1 = seldom 2 = sometimes 3 = frequent 4 = always

How often does your child get sleepy while doing homework?

0 = never 1 = seldom 2 = sometimes 3 = frequent 4 = always

Is your child alert most of the day? (Please note number change.)

4 = never 3 = seldom 2 = sometimes 1 = frequent 0 = always

How often is your child tired and grumpy during the day?

0 = never 1 = seldom 2 = sometimes 3 = frequent 4 = always

How often does your child have trouble getting out of bed in the morning?

0 = never 1 = seldom 2 = sometimes 3 = frequent 4 = always

How often does he or she fall back asleep after being awakened in the morning?

0 = never 1 = seldom 2 = sometimes 3 = frequent 4 = always

How often does your child need to be awakened by someone in the morning?

0 = never 1 = seldom 2 = sometimes 3 = frequent 4 = always

How often does your child think he/she needs more sleep?

0 = never 1 = seldom 2 = sometimes 3 = frequent 4 = always

Total = _____

Has your child ever felt unable to move while just falling asleep or waking up?

Yes No If yes, describe: _____

Has your child appeared to suddenly have muscle weakness or fallen after laughing, being surprised, or getting angry? Yes No If yes, describe:

Has your child ever had exceptionally vivid dreams *as you were falling asleep or waking up*? Yes No If yes, describe: _____

PLMS

RLS

OSAS

Does your child move excessively during sleep? Yes No

If yes, rarely occasionally frequently

Does your child awaken him/herself by kicking his/her legs?

Yes No If yes, rarely occasionally frequently

Does your child ever complain of a funny feeling in his or her legs that makes it difficult to fall asleep? Yes No

If yes, rarely occasionally frequently

If yes, describe: _____

Does your child snore? Yes No Unknown

If yes, is it occasionally or continuously;

and is it only when sleeping on the back or in any position.

Indicate the severity of your snoring by using the scale below:

Grade 1: Heard only if you listen close to the face

Grade 2: Heard in the room

Grade 3: Heard just outside the bedroom with the door open

Grade 4: Heard outside the bedroom with the door closed

Have you witnessed your child stop breathing during sleep?

Yes No If yes, rarely occasionally frequently

Does your child awaken gasping for air?

Yes No If yes, rarely occasionally frequently

Does your child awaken with a dry mouth?

Yes No If yes, rarely occasionally frequently

Does your child awaken with nasal congestion?

Yes No If yes, rarely occasionally frequently

Does your child complain of morning headaches?

Yes No If yes, rarely occasionally frequently

Does your child awaken with a sore throat?

Yes No If yes, rarely occasionally frequently

Does your child have night sweats? Yes No If yes, rarely
 occasionally frequently

Does your child complain of heartburn at night?
 Yes No If yes, rarely occasionally frequently

Does your child feel unrefreshed after sleeping?
 Yes No If yes, rarely occasionally frequently

Does your child have problems with memory or concentration?
 Yes No If yes, rarely occasionally frequently

Is your child ever appear confused in the morning?
 Yes No If yes, rarely occasionally frequently

How many times does your child awaken to urinate during the night?
 Yes No If yes, rarely occasionally frequently

Please tell us if there are any other concerns that you have about your sleep that were not covered in the above questionnaire:

Thank you for taking the time to fill out this questionnaire. We look forward to seeing you at your scheduled consultation.

*The Staff of the Sleep Disorders Center
of Central Texas*