Pediatric Sleep Questionnaire

Date: ______________________________

Name ____

D.O.B. ______/______/______ Age _________ Sex _________ Height _________ Weight _________

HISTORY

Briefly describe the problem your child is having with his or her sleep.

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Please check if your child currently has or has had any of the following:

_______ Snores loudly.

_______ Snores in all positions.

_______ Stops breathing at night.

_______ Wakes up gasping for breath.

_______ Wakes up coughing or choking.

_______ Frequent nightmares.

_______ Wakes up screaming.

_______ Behavioral issues.

_______ Hyperactive.

_______ Poor grades in school.

_______ Currently takes naps during the day.

_______ Feels sudden physical weakness during strong emotions (such as mouth dropping open or legs going limp during laughter or anger.)

_______ Excessively sleepy during the day.

_______ Excessive daytime fatigue.

_______ Sudden episodes of sleep during the day.

_______ Sleep walking.

_______ Bedwetting.

_______ Difficulty concentrating.

_______ Wakes up with a sour taste in their mouth.

_______ Sleep talk.

_______ Sleep walk.

_______ Restless sleep.

_______ Kicks or thrashes around at night.

_______ Difficulty maintaining sleep at night.

_______ Frequent awakenings.

SLEEP SCHEDULE

	Weekday:	Weekend:
What time does your child go to bed?	________ AM/PM	________ AM/PM
What time does your child wake up?	________ AM/PM	________ AM/PM
Average amount of sleep per night	________ hours	________ hours

Does your child share a bedroom with other siblings? ________ Yes ________ No
Does your child have a TV in the bedroom? ________ Yes ________ No

SYSTEMS REVIEW

Please check if your child currently has or has had any of the following:

Constitutional
_____ Fever _____ Weight gain _____ Weight loss _____ Fatigue _____ Night sweats

Eyes
_____ Pain _____ Redness _____ Loss of vision _____ Double or blurred vision _____ Dryness

Ears-Nose-Mouth-Throat
_____ Hearing loss _____ Nosebleeds _____ Loss of smell _____ Dryness in nose _____ Loss of taste
_____ Sores in mouth _____ Dryness of mouth _____ Hoarseness

Cardiovascular
_____ Chest Pain _____ Irregular heart beat _____ High blood pressure _____ Swollen legs or feet

Respiratory
_____ Shortness of Breath _____ Difficulty breathing at night _____ Cough _____ Coughing up blood
_____ Wheezing

Gastrointestinal
_____Loss of appetite _____Nausea _____Vomiting of blood or “coffee ground’ material
_____ Abdominal pain _____ Heartburn/reflux _____ Difficulty swallowing _____ Diarrhea
_____ Constipation _____ Blood in stools _____ Black stool

Urinary
_____ Difficult urination _____ Pain or burning on urination _____ Blood in urine
_____Discharge from penis/vagina _____Rash/ulcers

Musculoskeletal
_____ Morning stiffness _____ Joint pain or swelling _____ Muscle weakness _____ Muscle tenderness

Skin
_____Easy bruising _____Rashes _____Sun sensitivity _____Tightness _____Nodules/bumps
_____ Hair loss

Neurological
_____ Headaches _____ Dizziness _____ Weakness _____ Memory loss

Psychiatric
_____ Excessive worries _____ Anxiety _____ Easily loses temper _____ Depression _____ Agitation

Endocrine:
_____ Excessive thirst

Hematologic:
_____Swollen glands _____Tender glands _____Bleeding tendency _____Anemia _____Transfusions

SOCIAL HISTORY

Please check and answer all of the following:

Does your child drink coffee, tea, or soft drinks? ______Yes ______ No

If yes, regular ______ or decaffeinated ______ How much daily? ____________________________

How many meals does your child eat daily? 0 1 2 3 4 5

Does your child exercise regularly? ______Yes ______ No

If yes, what time of the day? ______ Morning ______ Mid-day ______ Evening

PAST MEDICAL HISTORY

Has your child had any surgeries? If yes, what year?

______ Appendectomy ____________________ ______ Ear nose or throat surgery_________________

______ Other ____________________________

Does your child have any history of the following medical problems? If yes, please mark.

______ Heart disease ______ Lung disease ______ Diabetes ______ Seizure disorder

______ Other (please explain)____

CURRENT MEDICATIONS

Medication list (Please list the name of each medication.)

____________________________ ______________________ ____________________________

____________________________ ______________________ ____________________________

____________________________ ______________________ ____________________________

Over the counter medications / herbal supplements

____

IMMEDIATE FAMILY (mother, father, siblings)

Person with disorder

Diabetes ________________________________

Heart disease ____________________________

High blood pressure _______________________

Stroke __________________________________

Obesity ________________________________

Person with disorder

Snoring _________________________________

Sleep Apnea _____________________________

Narcolepsy ______________________________

Daytime sleepiness ________________________

Other ___________________________________

Please add any other information you would like us to know that is not covered in this questionnaire.

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How did you choose Somnique Health? Check and explain all that apply.

_____ Physician ________________________

_____ On-line __________________________

_____ Friend ___________________________

_____ Newspaper _______________________

_____ Radio ___________________________

_____ Other ____________________________

Thank you for your time in filling this questionnaire out. It is a valuable tool for the physician.

Please bring this with you to your first appointment. We look forward to meeting you and your child!