



PEDIATRIC SLEEP QUESTIONNAIRE

Date: _____

Patient's Name: _____ Date of Birth _____

Age: _____ Height: _____ Weight: _____ Sex: __ Female __ Male

Questionnaire filled out by: _____ Relation to Patient _____

Tel Number: _____ Cell _____

Name of Referring Physician(s) _____ Phone: _____

_____ Phone: _____

Reason for Referral

Sleep apnea ___ Daytime sleeping ___ large tonsils ___ Bedwetting _____

Sleep Terror ___ Snoring ___ Sleep Walking ___ frequent awakenings _____

Hyperactivity ___ Others _____

A) Preparation for Sleep:

What is the usual supper time? _____

What does you child do from supper time till he/she goes to bed? _____

Where does he/she usually fall asleep? (His/her bed, sofa, parents' bed, etc)

B) Sleep Time:

Usual bedtime: Weekday _____ Weekend _____

How long does it take to fall asleep? _____

Usual hours of sleep: Weekday _____ Weekend _____

Does he/she wake up at night? ___ Yes ___ No

If yes, how often: _____ Reason _____

C) During sleep, does this patient:

Snore? _____ Loudly? _____ Snore throughout the night? _____
 How long? _____ Disturbing to others? _____
 Gasp for air? _____ Breathe through mouth? _____
 Stop Breathing? _____ Have restless sleep? _____
 Look pale? _____ blue? _____ Sound congested or stuffed? _____
 Make a snorting sound that wakes him/her from sleep? _____
 Have “growing pains” (unexplained leg pain)? _____
 Have “growing pains” that are worse at night? _____
 Kick with his/her legs briefly while asleep? _____
 Grind teeth at night? _____ Yes _____ No

D) Wake up Time/ Daytime Behavior:

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 _____
 Breathe through mouth _____ Wake up with headache in a.m. _____
Take nap: _____ how long? _____ When? _____

Hyperactivity/Inattention:

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

Teacher Observation:

Hyperactivity? _____ Short attention span? _____

Napping? _____ Falling grades? _____

E) Any Current Medical Problems?

1) _____

2) _____

3) _____

4) _____

F) Past Medical History:

1) _____

2) _____

3) _____

4) _____

G) Previous Surgery(s):

Medicine/Inhaler	Dose	How Often	Last Taken

I) Allergy to Medicine:

J) Other allergies (Food, seasonal, cats, etc): _____

K) Family History

Obstructive Sleep Apnea _____ Sleep Walking _____ Sleep Terror _____

Nightmare _____ Bed Wetting _____ Narcolepsy _____

Seizure _____ Asthma _____ GERD _____

Others _____

L) Review of Systems:

Any history of weight change?

___ Gain ___ Loss How much? _____ over how long? _____

Sleep Walking? _____ for how long? _____ how often? _____

Sleep Terror? _____ For how long? _____ How often? _____

Nightmare ? _____ For how long? _____ How often? _____

Sleep talking? _____ Others _____

Bedwetting? _____ For how long? _____

How Often /week or month? _____ Any treatment was given? _____

Frequent throat infections _____ Ear Infections _____

M) Social History/ Personal habits:

Drinks caffeinated beverages (coffee, tea, and cola) on a typical day? _____

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

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

Pets in the home? _____ Smoking? _____

N) Evaluation for Excessive Daytime Sleepiness:

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

If so, at what age did this develop? _____

Does your child have any sleepiness during the day? _____

If so, 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? _____

O) Evaluation of Insomnia/ Mood disorders

Difficulty initiating sleep_____ Maintaining sleep_____

Waking up early in the morning_____ Feeling fatigue during the day? _____

Feeling depressed ___ sad___ guilty_____ hopeless_____ Irritable _____

Inability to concentrate _____ Inability to remember things _____

Decrease or loss of appetite _____

P) Other Comments:
