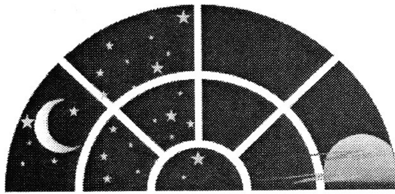

PEDIATRIC SLEEP CONSULT

SLEEP HISTORY QUESTIONNAIRE

Mid-Michigan Sleep Center
8203 S. Saginaw Street
Grand Blanc, MI 48439
Phone: (810) 953-3600 FAX: (810) 953-9547

BACKGROUND INFORMATION **Today's Date:**____________________

Name:____ Age: _____ Birthdate: ____________ Sex: _______

Home Phone:___________________ Parent Work Phone: ___________________Cell: __________________

Pharmacy of Choice: __________________________Parent Email: ________________________________

Mother's Name: _______________ Father's Name: ________________ Who is filling out history?_________

Patient's Approximate Height:___________ Weight Now:____________

Family Doctor: _____________________________ Referring Doctor: ________________________________

Please briefly describe why you were referred here or what problem you are having:

____

-How long have you had this problem? ______________Is your problem worsening?_____________________

MEDICATIONS/ INHALERS	Dose	Frequency
May make a separate list		

DRUG ALLERGIES	Reaction

OTHER ALLERGIES	Reaction

SURGICAL HISTORY	Date

DIAGNOSED MEDICAL CONDITIONS (check off)

☐ ADHD/ADD	☐ THYROID	☐ HEART
☐ ASTHMA	☐ REFLUX/GERD	☐ DIABETES
☐ CHROMOSOME	☐ PREMATURE	☐ MONONUCLEOSIS
☐ EPILEPSY	☐ BIRTH DEFECT	☐ DELAYED GROWTH
☐ ARTHRITIS	☐ MIGRAINES	☐ OBESITY
☐ HIGH BLOOD PRESSURE	☐	☐

GENERAL REVIEW OF SYSTEMS

☐ Weight Change	☐ Fever/Chills	☐ Appetite change
☐ Weakness	☐ Rashes/Itching	☐ Color Changes
☐ Ear Discharge	☐ Earaches	☐ Eye Redness
☐ Eye Pain	☐ Eye Discharge	☐ Stuffy Nose
☐ Sinus Pain	☐ Itchy nose	☐ Nosebleeds
☐ Hay fever	☐ Dry Mouth	☐ Dental Device
☐ Oral Thrush	☐ Sore Throat	☐ Sores in Mouth
☐ Swallowing Problems	☐ Swollen Glands	☐ Neck Stiffness
☐ Lumps in neck	☐ Hoarseness	☐ Wheezing
☐ Short of breath	☐ Fast Breathing	☐ Chest Tightness
☐ Cough	☐ Hernia	☐ Chest Pain
☐ Heart Palpitations	☐ Difficulty breath-ing laying down	☐ Swelling (Edema)
☐ Genitalia—itching/ rash	☐ Blood in Urine	☐ Pain with urination
☐ Heartburn	☐ Nausea	☐ Jaundice
☐ Diarrhea	☐ Constipation	☐ Leg Cramping
☐ Bruise Easily	☐ Joint Redness	☐ Muscle/Joint pain
☐ Freq. Urination	☐ Numbness/ Tingling	☐ Heat/Cold Intolerance
☐ Dizziness	☐ Fainting	☐ Tremor
☐ Sweating	☐ Memory Loss	☐ Hyperactivity
☐ Nervousness	☐ Seizures	☐ Feeling Depressed

MEDICAL CONDITIONS (additional)

PEDIATRIC SLEEP HISTORY QUESTIONNAIRE
(to be completed by patient)

HAS YOUR CHILD BEEN DIAGNOSED WITH A SLEEP DISORDER BEFORE? _______
If yes, when and what disorder?

____

____

Has he/she had a previous Sleep Study?_______
Where & when?

____

SYMPTOMS RELATED TO SLEEP

Please check if you experience any of the following symptoms when sleeping or trying to sleep.

- ☐ Loud snoring
- ☐ Breathing or snoring stops in sleep
- ☐ Awaken gasping for breath or choking
- ☐ Hard to wake up in the morning
- ☐ Feels sleepy during day
- ☐ Restless Sleep
- ☐ Observed Apnea (stops breathing) while asleep
- ☐ Grind teeth at night
- ☐ Pains in legs. Worse at night?______
- ☐ Irresistible urge to move legs or arms
- ☐ Mouth breathing/dry mouth
- ☐ Sounds congested or stuffed up
- ☐ Frequent throat infections
- ☐ Frequent ear infections
- ☐ Sleepwalking, Sleep talking, Sleep Terrors
- ☐ Bedwetting
- ☐ Difficulty falling asleep
- ☐ Difficulty staying asleep
- ☐ Feel sad or hopeless
- ☐ Difficulty sustaining attention, does not finish tasks
- ☐ Irritability/Depression
- ☐ Fall out of bed while asleep
- ☐ Color changes—appears pale or blue
- ☐ Difficult to wake in morning
- ☐ Morning headaches
- ☐ Falling grades at school
- ☐ Have vivid dreams upon sleep onset or wake
- ☐ Irresistable urge to nap or naps at school or on short car rides
- ☐ Weakness in muscles when laughing, angry, surprised or excited
- ☐ Unable to move at sleep onset or awakening
- ☐ Ever sensed he/she was dreaming while awake

SLEEP HABITS

1) Bedtime? Weekday____AM/PM Weekend____AM/PM
2) How long does it take him/her to fall asleep after you have turned out the lights? _________minutes/hours?
3) How often does child awaken each night?________________
4) Average hours of sleep? Weekday____hrs Wkend ______hrs
5) Time wake for day? Wkday_____AM/PM Wkend____AM/PM
6) Where does child fall asleep at night?_____________
7) Does child stay in own bed all night?______________
8) Indicate total length of naps daily? _______________
9) What time is usual supper time? _________PM
10) Regular bedtime routine?______________________

GROWTH & DEVELOPMENT HISTORY

Has child had any weight problems?_______________

Recent gain? _____(pounds). Recent loss?______(pounds)

Any concerns about growth? ________________________

SOCIAL HISTORY

Any smoking? ________ Smoke Exposure?________

# of years smoking ________ How much per day?______

Alcohol Abuse? ___________ Drug Abuse?_________

How many caffeinated beverages on typical day?_____

Caffeine (coffee, tea, cola) ?______________________

Caffeine after noon?______ Caffeine all day?________

Lives at home with parents?______foster parents?_______
Marital status of parents:
Married___Single___Divorced___Separated______
Shared custody?______ Does he/she share a bedroom?____
Number of Siblings: _________________________________
Pets at home____

Participate in sports or regular exercise?
Current grades?______ Ever repeat a grade?______
Child enrolled in special education classes?________
Grades this year? Excellent___Good___Avg___Poor___Failing___
Grades last year. Excellent___Good___Avg___Poor___Failing___

FAMILY HISTORY (check all that apply)
Is there a family history of:

	Mother	Father	Brother	Sister	Gparent
APNEA					
BED WETTING					
INSOMNIA					
RESTLESS LEGS SYNDROME					
Other Sleep DISTURBANCES					
ASTHMA					
GERD					