



Welcome to Guam Sleep Center. Filling out this questionnaire will help your doctor focus on your child's specific sleep problem. Thank you for your cooperation!

PEDIATRIC SLEEP HISTORY QUESTIONNAIRE

PATIENT NAME: _____

ADDRESS: _____

PHONE NO: DAY: _____ EVENINGS: _____

AGE: _____ SEX: _____ HEIGHT: _____ WEIGHT: _____

REFERRING PHYSICIAN: _____ PHONE: _____

ADDRESS: _____

OTHER PHYSICIAN YOU WOULD LIKE US TO SEND A REPORT TO:

NAME: _____ PHONE: _____

ADDRESS: _____

WHAT IS YOUR MAIN CONCERN ABOUT YOUR CHILD'S SLEEP PROBLEM?

WHEN DID THIS PROBLEM BEGIN?

IS IT GETTING WORSE? YES _____ NO _____

HAS YOUR CHILD EVER HAD A SLEEP STUDY? YES _____ NO _____

IF YES, WHEN? _____ RESULTS: _____

Weekly Sleep Schedule

Write in the amount of time the child sleeps during a 24 hour period on weekdays. (add daytime and nighttime sleep)

_____ hours _____ minutes

Child's usual bedtime on weekday nights _____:

Child's usual wake time on weekday mornings _____:

Child's usual bedtime on weekend nights _____:

Child's usual wake time on weekend mornings _____:

Number of naps during the day _____ length of naps _____

Sleep Environment

- 1. Where does your child usually sleep? _____
- 2. Does your child sleep alone? _____
- 3. Does your child watch tv/play video games while in bed? _____
- 4. Does your child have his/her own room? _____
- 5. Is your child able to fall asleep on his/her own? _____
- 6. Does your child wake during the night? If yes, how many times? _____
- 7. Is your child hard to wake up in the morning? _____

Current Sleep Symptoms

Please circle number of times per week

- | | | | | | |
|--|---|-----|-----|-----|-------------|
| 1. Difficulty breathing when asleep | 0 | 1-2 | 3-4 | 5-6 | every night |
| 2. Stops breathing during sleep | 0 | 1-2 | 3-4 | 5-6 | every night |
| 3. Snores or noisy breathing while asleep | 0 | 1-2 | 3-4 | 5-6 | every night |
| 4. Turns pale or blue during sleep | 0 | 1-2 | 3-4 | 5-6 | every night |
| 5. Restless sleep/tossing and turning | 0 | 1-2 | 3-4 | 5-6 | every night |
| 6. Sweating while sleeping | 0 | 1-2 | 3-4 | 5-6 | every night |
| 7. Daytime sleepiness/naps after school | 0 | 1-2 | 3-4 | 5-6 | every night |
| 8. Falls asleep in school | 0 | 1-2 | 3-4 | 5-6 | every night |
| 9. Poor appetite | 0 | 1-2 | 3-4 | 5-6 | every night |
| 10. Nightmares/night terrors | 0 | 1-2 | 3-4 | 5-6 | every night |
| 11. Sleep talks | 0 | 1-2 | 3-4 | 5-6 | every night |
| 12. Kick or moves arms/legs during sleep | 0 | 1-2 | 3-4 | 5-6 | every night |
| 13. Wets the bed | 0 | 1-2 | 3-4 | 5-6 | every night |
| 14. Creepy-crawly/uncomfortable feeling in legs | 0 | 1-2 | 3-4 | 5-6 | every night |
| 15. Resists going to bed | 0 | 1-2 | 3-4 | 5-6 | every night |
| 16. Wakes up at night | 0 | 1-2 | 3-4 | 5-6 | every night |
| 17. Gets out of bed at night | 0 | 1-2 | 3-4 | 5-6 | every night |
| 18. Grinds teeth while asleep | 0 | 1-2 | 3-4 | 5-6 | every night |
| 19. Trouble getting up in the morning | 0 | 1-2 | 3-4 | 5-6 | every night |
| 20. Sees frightening images before falling asleep | 0 | 1-2 | 3-4 | 5-6 | every night |
| 21. Feels weak or loses control of muscles Suddenly with strong emotions (laughter, anger, crying, etc.) while awake | 0 | 1-2 | 3-4 | 5-6 | every night |
| 22. Screaming in sleep | 0 | 1-2 | 3-4 | 5-6 | every night |

Past Medical History (please circle)

| | | | |
|---|-----|----|------|
| 1. Frequent nasal congestion/ Sinus problems | Yes | No | Age: |
| 2. Trouble breathing through nose | Yes | No | Age: |
| 3. Enlarged tonsils/Enlarged adenoids | Yes | No | Age: |
| 4. Chronic cough/Bronchitis | Yes | No | Age: |
| 5. Allergies | Yes | No | Age: |
| 6. Asthma | Yes | No | Age: |
| 7. Frequent colds or flu | Yes | No | Age: |
| 8. Frequent strep throat | Yes | No | Age: |
| 9. Had tonsils out | Yes | No | Age: |
| 10. Frequent ear infections | Yes | No | Age: |
| 11. Ear tubes placed | Yes | No | Age: |
| 12. Difficulty swallowing | Yes | No | Age: |
| 13. Acid reflux / GER | Yes | No | Age: |
| 14. Poor or delayed growth | Yes | No | Age: |
| 15. Excessive weight | Yes | No | Age: |
| 16. Neurologic or muscular disorder | Yes | No | Age: |
| 17. Cerebral Palsy | Yes | No | Age: |
| 18. Seizure/Epilepsy | Yes | No | Age: |
| 19. Morning headaches | Yes | No | Age: |
| 20. Chromosomal disorder (e.g. Down's syndrome) | Yes | No | Age: |
| 21. Skeleton problems (e.g. Dwarfism) | Yes | No | Age: |
| 22. Genetic disorder | Yes | No | Age: |
| 23. Craniofacial disorder (e.g. Pierre-Robin) | Yes | No | Age: |
| 24. Thyroid problems | Yes | No | Age: |
| 25. Pain | Yes | No | Age: |
| 26. Meningitis | Yes | No | Age: |
| 27. Autism | Yes | No | Age: |
| 28. Developmental Delay | Yes | No | Age: |
| 29. Hyperactivity/ ADHD | Yes | No | Age: |
| 30. Anxiety / Panic Attacks | Yes | No | Age: |
| 31. Obsessive Compulsive Disorder | Yes | No | Age: |
| 32. Depression | Yes | No | Age: |
| 33. Suicide | Yes | No | Age: |
| 34. Learning disabilities | Yes | No | Age: |
| 35. Drug use/ abuse | Yes | No | Age: |
| 36. Behavioral disorder | Yes | No | Age: |
| 37. Psychiatric admission | Yes | No | Age: |

Birth History:

Any problems with pregnancy or delivery? _____

Was your child born on time? Yes/No If no, how many weeks?_____

What was your child's birthweight? _____lbs _____oz

Please list any hospitalizations or other medical diagnosis your child has had below:

DOES YOUR CHILD TAKE ANY MEDICATIONS? NO _____ YES _____

IF YES PLEASE LIST NAMES, DOSAGE, AND REASON FOR TAKING THEM.

| NAME | DOSAGE | TAKEN FOR |
|------|--------|-----------|
| | | |
| | | |
| | | |

DOES ANYONE IN YOUR FAMILY (BLOOD RELATIVES ONLY) HAVE A HISTORY OF ANY OF THE FOLLOWING SLEEP PROBLEMS? (PLEASE CIRCLE AND INDICATE WHO)

- | | | | |
|--|-----|----|----------------|
| 1. Insomnia (inability to fall asleep) | Yes | No | relation:_____ |
| 2. Sleep Apnea | Yes | No | relation:_____ |
| 3. Restless Leg Syndrome | Yes | No | relation:_____ |
| 4. Periodic Limb Movements in Sleep (PLMS) | Yes | No | relation:_____ |
| 5. Sleepwalking/sleep terrors | Yes | No | relation:_____ |
| 6. Sleep talking | Yes | No | relation:_____ |
| 7. Narcolepsy (inability to stay awake) | Yes | No | relation:_____ |
| 8. Snoring | Yes | No | relation:_____ |

SCHOOL PERFORMANCE (if school age)

- | | |
|---|--------|
| 1. Have you noticed a recent change in your child's school performance? | Yes/No |
| 2. What grade is your child in? _____ | |
| 3. Has your child ever repeated a grade? if yes, what grade(s)_____ | Yes/No |
| 4. Is your child enrolled in any special education classes? | Yes/No |
| 5. How many school days has your child missed so far this year? | _____ |
| 6. How many school days did your child miss last year? | _____ |
| 7. How many school days has your child been tardy? | _____ |
| 8. How many school days was your child tardy last year? | _____ |
| 9. Child's grades this year? Excellent Good Average Poor Failing | |
| 10. Child's grades last year? Excellent Good Average Poor Failing | |

WHAT DOES YOUR CHILD LIKE TO DO IN HIS/HER SPARE TIME (HOBBIES, CRAFTS, ORGANIZATIONS, CLUBS, AND SPORTS)? PLEASE LIST: _____

DOES ANYONE IN THE HOUSE SMOKE? NO _____ YES _____

HOW MUCH OF THE FOLLOWING BEVERAGES CONTAINING CAFFEINE DOES YOUR CHILD DRINK IN AN AVERAGE 24-HOUR PERIOD? COFFEE _____ TEA _____ COCA-COLA _____

PLEASE ADD ANY COMMENTS OR PROBLEMS NOT LISTED IN THIS QUESTIONNAIRE:

THANK YOU!