GUAM SLEEP CENTER

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ACCREDITED MEMBER CENTER

PEDIATRIC SLEEP HISTORY QUESTIONNAIRE

Welcome to Guam Sleep Center! Your responses in this questionnaire will help our sleep specialist focus on your child's specific sleep problem. Thank you for your cooperation.

TODAY'S DATE: _____

PATIENT NAME: _____

PARENT(S)/LEGAL GUARDIAN(S): _____

ADDRESS: _____

_____

PHONE NO: DAY: _____ EVENINGS: _____

AGE: _____ SEX: _____ HEIGHT (in): _____ WEIGHT(lbs): _____

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?

_____

_____

WHEN DID THIS PROBLEM BEGIN? _____ IS IT GETTING WORSE? ☐NO ☐YES

HAS YOUR CHILD EVER HAD A SLEEP STUDY? ☐NO ☐YES IF YES, WHEN? (MM/DD/YYYY) _____

RESULTS: _____

WEEKDAYS/WEEKNIGHTS

HOW MANY NAPS TAKEN DURING THE DAY?	
LENGTH OF NAPS	
CHILD'S USUAL BED TIME	
CHILD'S USUAL WAKE TIME	

WEEKENDS

HOW MANY NAPS TAKEN DURING THE DAY?	
LENGTH OF NAPS	
CHILD'S USUAL BED TIME	
CHILD'S USUAL WAKE TIME	

HOW MUCH TIME DOES YOUR CHILD SLEEP IN A 24-HR PERIOD ON **WEEKDAYS**? (DAYTIME + NIGHTTIME SLEEP):

_____ **HRS** _____ **MINS**

SLEEP ENVIRONMENT

1. WHERE DOES YOUR CHILD USUALLY SLEEP? _____
2. DOES YOUR CHILD SLEEP ALONE? ☐NO ☐YES
3. DOES YOUR CHILD WATCH TV/PLAY VIDEO GAMES WHILE IN BED? ☐NO ☐YES
4. DOES YOUR CHILD HAVE HIS/HER OWN BEDROOM? ☐NO ☐YES
5. IS YOUR CHILD ABLE TO FALL ASLEEP ON HIS/HER OWN? ☐NO ☐YES
6. DOES YOUR CHILD WAKE DURING THE NIGHT? ☐NO ☐YES
7. IF YES, HOW MANY TIMES? _____
8. IS YOUR CHILD HARD TO WAKE UP IN THE MORNING? ☐NO ☐YES

CURRENT SLEEP SYMPTOMS *Please indicate 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. SNORING 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 DAY
8. FALLS ASLEEP IN SCHOOL	☐0	☐1-2	☐3-4	☐5-6	☐EVERY DAY
9. POOR APPETITE	☐0	☐1-2	☐3-4	☐5-6	☐EVERY DAY
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 DAY
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 DAY
22. SCREAMING IN SLEEP	☐0	☐1-2	☐3-4	☐5-6	☐EVERY NIGHT

CURRENT MEDICATIONS

DOES YOUR CHILD TAKE ANY MEDICATIONS? ☐NO ☐YES
IF YES PLEASE LIST NAMES, DOSAGE, AND MEDICAL REASON FOR TAKING THEM:

NAME	DOSAGE	REASON TAKEN

BIRTH HISTORY

WERE THERE ANY PROBLEMS WITH PREGNANCY OR DELIVERY? ☐NO ☐YES

IF YES, PLEASE SPECIFY: _____

WAS YOUR CHILD BORN ON TIME? ☐NO ☐YES IF NO, HOW MANY WEEKS? _____

WHAT WAS YOUR CHILD'S BIRTH WEIGHT? _____ LBS _____ OZ

PAST MEDICAL HISTORY *Please specify "No" or "Yes" and child's age at the time each began or occurred.*

1. FREQUENT NASAL CONGESTION/ SINUS PROBLEMS	☐NO	☐YES	IF YES, AGE:_____
2. TROUBLE BREATHING THROUGH NOSE	☐NO	☐YES	IF YES, AGE:_____
3. ENLARGED TONSILS/ENLARGED ADENOIDS	☐NO	☐YES	IF YES, AGE:_____
4. CHRONIC COUGH/BRONCHITIS	☐NO	☐YES	IF YES, AGE:_____
5. ALLERGIES	☐NO	☐YES	IF YES, AGE:_____
6. ASTHMA	☐NO	☐YES	IF YES, AGE:_____
7. FREQUENT COLDS OR FLU	☐NO	☐YES	IF YES, AGE:_____
8. FREQUENT STREP THROAT	☐NO	☐YES	IF YES, AGE:_____
9. HAD TONSILS REMOVED	☐NO	☐YES	IF YES, AGE:_____
10. FREQUENT EAR INFECTIONS	☐NO	☐YES	IF YES, AGE:_____
11. EAR TUBES PLACED	☐NO	☐YES	IF YES, AGE:_____
12. DIFFICULTY SWALLOWING	☐NO	☐YES	IF YES, AGE:_____
13. ACID REFLUX / GERD	☐NO	☐YES	IF YES, AGE:_____
14. POOR OR DELAYED GROWTH	☐NO	☐YES	IF YES, AGE:_____
15. EXCESSIVE WEIGHT	☐NO	☐YES	IF YES, AGE:_____
16. NEUROLOGIC OR MUSCULAR DISORDER	☐NO	☐YES	IF YES, AGE:_____
17. CEREBRAL PALSY	☐NO	☐YES	IF YES, AGE:_____
18. SEIZURE/EPILEPSY	☐NO	☐YES	IF YES, AGE:_____
19. MORNING HEADACHES	☐NO	☐YES	IF YES, AGE:_____
20. CHROMOSOMAL DISORDER (E.G. DOWN'S SYNDROME)	☐NO	☐YES	IF YES, AGE:_____
21. SKELETON PROBLEMS (E.G. DWARFISM)	☐NO	☐YES	IF YES, AGE:_____
22. GENETIC DISORDER	☐NO	☐YES	IF YES, AGE:_____
23. CRANIOFACIAL DISORDER (E.G. PIERRE-ROBIN)	☐NO	☐YES	IF YES, AGE:_____
24. THYROID PROBLEMS	☐NO	☐YES	IF YES, AGE:_____
25. PAIN	☐NO	☐YES	IF YES, AGE:_____
26. MENINGITIS	☐NO	☐YES	IF YES, AGE:_____
27. AUTISM	☐NO	☐YES	IF YES, AGE:_____
28. DEVELOPMENTAL DELAY	☐NO	☐YES	IF YES, AGE:_____
29. HYPERACTIVITY/ ADHD	☐NO	☐YES	IF YES, AGE:_____
30. ANXIETY / PANIC ATTACKS	☐NO	☐YES	IF YES, AGE:_____
31. OBSESSIVE-COMPULSIVE DISORDER	☐NO	☐YES	IF YES, AGE:_____
32. DEPRESSION	☐NO	☐YES	IF YES, AGE:_____
33. SUICIDE	☐NO	☐YES	IF YES, AGE:_____
34. LEARNING DISABILITIES	☐NO	☐YES	IF YES, AGE:_____
35. DRUG USE/ ABUSE	☐NO	☐YES	IF YES, AGE:_____
36. BEHAVIORAL DISORDER	☐NO	☐YES	IF YES, AGE:_____
37. PSYCHIATRIC ADMISSION	☐NO	☐YES	IF YES, AGE:_____

PLEASE LIST ANY HOSPITALIZATIONS OR OTHER MEDICAL DIAGNOSIS YOUR CHILD HAS HAD BELOW:

_____

_____

FAMILY HISTORY

DOES ANYONE IN YOUR FAMILY (BLOOD RELATIVES ONLY) HAVE A HISTORY OF ANY OF THE FOLLOWING SLEEP PROBLEMS? (PLEASE INDICATE "NO" OR "YES" AND RELATION TO CHILD):

1. INSOMNIA (INABILITY TO FALL ASLEEP) ☐NO ☐YES RELATION:_____
2. SLEEP APNEA ☐NO ☐YES RELATION:_____
3. RESTLESS LEG SYNDROME ☐NO ☐YES RELATION:_____
4. PERIODIC LIMB MOVEMENTS IN SLEEP (PLMS) ☐NO ☐YES RELATION:_____
5. SLEEPWALKING/SLEEP TERRORS ☐NO ☐YES RELATION:_____
6. SLEEP TALKING ☐NO ☐YES RELATION:_____
7. NARCOLEPSY (INABILITY TO STAY AWAKE) ☐NO ☐YES RELATION:_____
8. SNORING ☐NO ☐YES RELATION:_____

SCHOOL PERFORMANCE *(If of school age)*

1. HAVE YOU NOTICED A RECENT CHANGE IN YOUR CHILD'S SCHOOL PERFORMANCE? ☐NO ☐YES
2. IS YOUR CHILD ENROLLED IN ANY SPECIAL EDUCATION CLASSES? ☐NO ☐YES
3. HAS YOUR CHILD EVER REPEATED A GRADE? ☐NO ☐YES IF YES, WHAT GRADE(S) _____
4. WHAT GRADE IS YOUR CHILD IN THIS SCHOOL YEAR? _____
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 THIS YEAR? _____
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

MISCELLANEOUS

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 MANY CUPS OR CANS OF THE FOLLOWING CAFFEINATED BEVERAGES DOES YOUR CHILD DRINK IN AN AVERAGE 24-HR PERIOD? (PLEASE SPECIFY IF CUPS OR CANS)

_____COFFEE _____TEA _____SODA _____OTHER (PLEASE SPECIFY)

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

_____

_____

_____

QUESTIONNAIRE COMPLETED BY:_____ **RELATION TO PATIENT:**_____

Thank you for completing our questionnaire!

FOR PHYSICIAN'S USE ONLY			
BP: _____	HR: _____	O2: _____	RESP. RATE: _____