**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:**  ________________________________________________________________________

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**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:** _______________________________________________________________________________________

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**WEEKDAYS/WEEKNIGHTS**

<table>
<thead>
<tr>
<th>HOW MANY NAPS TAKEN DURING THE DAY?</th>
<th>LENGTH OF NAPS</th>
<th>CHILD’S USUAL BED TIME</th>
<th>CHILD’S USUAL WAKE TIME</th>
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**HOW MUCH TIME DOES YOUR CHILD SLEEP IN A 24-HR PERIOD ON WEEKDAYS? (DAYTIME + NIGHTTIME SLEEP):**

_________ HRS   _________ MINS

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Page 1 of 4
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:

<table>
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<tr>
<th>NAME</th>
<th>DOSAGE</th>
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Page 2 of 4
**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: ________