Pediatric Sleep History Questionnaire

Name: ___________________________ Height: _______ Weight: _______ Sex: _______
Birth Date: _______ Age: _______ School Grade: _______ Number of siblings: _______

Please complete these questions as thoroughly as you can.

1. Describe the main problem(s) in your own words. Include when and how it began and what evaluations and treatments have been tried.

2. How often does this problem occur?
   ( ) almost every night
   ( ) at least once a week
   ( ) irregularly
   ( ) Other: ___________________________________________________

3. How long has this been a problem?
   ( ) longer than 2 years
   ( ) 1 to 2 years
   ( ) several months
   ( ) within the last 3 months

4. On the scale below, please estimate the severity of the problem.
   ( ) mildly upsetting
   ( ) moderately severe
   ( ) very severe
   ( ) extremely severe
   ( ) totally incapacitating

5. How do you describe the sleep problems? Check all that apply.
   ( ) difficulty falling asleep
   ( ) wake up during the night
   ( ) wake up early in the morning
   ( ) excessive daytime sleepiness
   ( ) difficulty awakening
   ( ) bed wetting
   ( ) nightmares
   ( ) sleep walking
   ( ) eating during the night
6. Do any other family members have sleep problems? Please explain.

7. Have you ever consulted with any of the following to help with a sleep problem or daytime sleepiness?
   ( ) general practitioner
   ( ) pediatrician
   ( ) ear, nose, throat doctor
   ( ) internist
   ( ) psychiatrist
   ( ) psychologist
   ( ) other physician
   ( ) clinical psychologist
   ( ) chiropractor
   ( ) nutritionist
   ( ) social worker
   ( ) internist
   ( ) psychiatrist
   ( ) other physician
   ( ) clinical psychologist
   ( ) chiropractor
   ( ) nutritionist
   ( ) social worker

8. What treatments have been tried?

9. Please rate how often the child:

   N: Never  R: Rarely (less than once per month)  O: Occasionally (1-4 times per month)
   F: Frequently (5 times per month or a few times per week)  C: Constantly (almost nightly)

<table>
<thead>
<tr>
<th>Condition</th>
<th>N</th>
<th>R</th>
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<tbody>
<tr>
<td>Awakens from sleep short of breath</td>
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<tr>
<td>Awakens from sleep with heartburn, belching, or cough</td>
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<td>Snores</td>
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<td>Snores loudly enough so others complain</td>
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<td>Suddenly wakes up gasping for breath</td>
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<td>Sweats excessively at night</td>
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<td>Wets the bed</td>
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<td>Falls asleep during the day</td>
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<td>Falls asleep involuntarily</td>
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<td>Falls asleep during physical effort</td>
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<td>Falls asleep laughing or crying</td>
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<td>Experiences loss of muscle tone when extremely emotional</td>
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<td>Has trouble at school or work because of sleepiness</td>
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<td>Feels unable to move or become paralyzed upon waking or falling asleep</td>
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<td>Experiences vivid dreamlike scenes upon waking or falling asleep</td>
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<td>Feels afraid of going to sleep</td>
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<td>Has nightmares</td>
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<td>Awakens screaming or terrified</td>
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<td>Has thoughts racing through his or her mind</td>
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<td>Feels sad or depressed</td>
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<td>Has anxiety</td>
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<td>Notices parts of his or her body jerk at night</td>
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<td>Kicks during the night</td>
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<td>Experiences crawling or aching feelings in the legs</td>
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<td>Experiences any type of leg pain during the night</td>
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<td>Has morning jaw pain</td>
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<td>Grinds teeth during sleep</td>
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<td>Is awakened by pain during the night</td>
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</tbody>
</table>
N: Never  R: Rarely (less than once per month)  O: Occasionally (1-4 times per month)  F: Frequently (5 times per month or a few times per week)  C: Constantly (almost nightly)

<table>
<thead>
<tr>
<th>Wakes up with pain</th>
<th>N</th>
<th>R</th>
<th>O</th>
<th>F</th>
<th>C</th>
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</thead>
<tbody>
<tr>
<td>Sleep walks</td>
<td>N</td>
<td>R</td>
<td>O</td>
<td>F</td>
<td>C</td>
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<tr>
<td>Talks in his or her sleep</td>
<td>N</td>
<td>R</td>
<td>O</td>
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<td>C</td>
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</tbody>
</table>

10. Is the patient’s present school performance satisfactory? Has school performance changed?

11. Please circle any of the following that apply to the patient.

- Headaches
- Palpitations
- Bowel disturbances
- Nightmares
- Feel tense
- Depressed
- Unable to relax
- Doesn't like weekends or vacations
- Can’t make friends
- Wet the bed
- No appetite
- Uses alcohol
- Take drugs
- Unable to have a good time
- Dizziness
- Stomach troubles
- Fatigue
- Do well in school
- Feel panicky
- Sexual problems
- Over ambitious
- Memory problems
- Fainting spells
- Insomnia
- Tremors
- Shy with people
- Home conditions bad
- Concentration difficulties
- Do poorly in school

12. How has the sleep problem affected the patient’s social activities?

13. How many hours of sleep does the patient usually get per night?

14. What is the usual bedtime on weekdays? Weekends?

15. How long does it take for the patient to fall asleep?

16. How many times does the patient typically wake up at night?

17. If the patient wakes up, on the average, how long does he or she stay awake?

18. If he or she awakens during the night (after falling asleep) when does it happen?

   - soon after falling asleep
   - middle of the night
   - early morning

19. What does the patient usually do when he or she awakens during the night?

20. What time does the patient usually awaken in the morning on weekdays? Weekends?
21. Does the patient usually:
   ( ) sleep with someone else in his or her bed?
   ( ) sleep with someone else in his or her room?
   ( ) sleep with pets in his or her room or bed?

22. Is the patient’s sleep often disturbed by:
   ( ) heat
   ( ) cold
   ( ) noise
   ( ) light
   ( ) brother or sister
   ( ) not being in your usual bed
   ( ) other

23. Are the patient’s sleep habits different on weekends from weekdays?
   ( ) No
   ( ) Yes (Please explain)

24. With whom is the patient now living? (mother, father, sisters, brothers, etc.) Please include ages.

25. Does the patient usually drink cola or other caffeinated beverages within 2 hours of bedtime?
   ( ) No
   ( ) Yes

26. Does the patient do physical exercise before bedtime? ( ) No ( ) Yes

27. Does the patient read before falling asleep? ( ) No ( ) Yes

28. Does the patient watch TV in bed before falling asleep? ( ) No ( ) Yes

29. Does the patient take naps during the afternoon or evening? ( ) No ( ) Yes

30. Does the patient feel refreshed after a short (10 to 15 minutes) nap? ( ) No ( ) Yes ( ) Don’t know

31. How does the patient feel after an average night of sleep?
   ( ) drowsy or tired for ( ) 1 ( ) 2 ( ) 3 or more hours
   ( ) awake and refreshed some or most of the time
   ( ) almost always awake and refreshed

32. Does the patient feel better during the ( ) morning ( ) afternoon ( ) evening

33. List all medications that the patient currently takes.

<table>
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<tr>
<th>Medication</th>
<th>Amount</th>
<th>How often</th>
<th>Reason</th>
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</table>

34. List the patient’s use of the following (if known):

   Cigarettes   ( ) Smoke _____ packs per day for _____ years
   ( ) Quit _____ years / months ago
   ( ) Never smoked

   Caffeine     ( ) _____ drinks of coffee, tea, and/ or caffeinated soda per day
   ( ) None
Alcohol  ( ) ____ drinks per day ( ) every day ( ) ____ days per ____________
( ) use as a sleep aid ( ) never

Recreational Drugs
( ) No
( ) Yes ( ) daily ( ) ____ days per __________

Medical History

Date of last physical exam: ____________
The patient’s current health is ( ) Excellent ( ) Very Good ( ) Good ( ) Fair ( ) Poor
D=Don’t know N=Never R=Rarely O=Occasionally F=Frequently A=Always

Please rate how often the following things occur:

<table>
<thead>
<tr>
<th></th>
<th>D</th>
<th>N</th>
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</thead>
<tbody>
<tr>
<td>Snoring</td>
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<tr>
<td>Breathing stops during sleep</td>
<td>D</td>
<td>N</td>
<td>R</td>
<td>O</td>
<td>F</td>
<td>A</td>
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<tr>
<td>Heartburn at night</td>
<td>D</td>
<td>N</td>
<td>R</td>
<td>O</td>
<td>F</td>
<td>A</td>
</tr>
<tr>
<td>Morning headaches</td>
<td>D</td>
<td>N</td>
<td>R</td>
<td>O</td>
<td>F</td>
<td>A</td>
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<tr>
<td>Awake refreshed</td>
<td>D</td>
<td>N</td>
<td>R</td>
<td>O</td>
<td>F</td>
<td>A</td>
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<tr>
<td>Daytime sleepiness</td>
<td>D</td>
<td>N</td>
<td>R</td>
<td>O</td>
<td>F</td>
<td>A</td>
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<tr>
<td>Memory problems</td>
<td>D</td>
<td>N</td>
<td>R</td>
<td>O</td>
<td>F</td>
<td>A</td>
</tr>
<tr>
<td>Concentration problems</td>
<td>D</td>
<td>N</td>
<td>R</td>
<td>O</td>
<td>F</td>
<td>A</td>
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<tr>
<td>Job problems related to sleepiness</td>
<td>D</td>
<td>N</td>
<td>R</td>
<td>O</td>
<td>F</td>
<td>A</td>
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<tr>
<td>Bed wetting</td>
<td>D</td>
<td>N</td>
<td>R</td>
<td>O</td>
<td>F</td>
<td>A</td>
</tr>
<tr>
<td>Irritability</td>
<td>D</td>
<td>N</td>
<td>R</td>
<td>O</td>
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</table>

Number of sick days in last 6 months ( ) 0 ( ) 1-3 ( ) 4-6 ( ) 7-9 ( ) 10+
Number of doctor visits in last 6 months ( ) 0 ( ) 1-3 ( ) 4-6 ( ) 7-9 ( ) 10+

Does the patient have:

- Asthma ( ) No ( ) Yes
- Cystic Fibrosis ( ) No ( ) Yes
- Heart disease ( ) No ( ) Yes
- Acid reflux ( ) No ( ) Yes
- High blood pressure ( ) No ( ) Yes
- Nasal Allergies ( ) No ( ) Yes
- Diabetes ( ) No ( ) Yes
- Attention Deficit Disorder ( ) No ( ) Yes
- Depression ( ) No ( ) Yes
- Seizures ( ) No ( ) Yes

Please list any surgeries the patient has had and whether there were complications with surgery or anesthesia. (tonsils, adenoids, nose, heart surgery)

Please list any medication allergies:

Please describe any past or current problems with the following:
Birth History (prematurity, birth trauma, infections, etc.)

Mental health (depression, alcohol or drug use, behavior problems, etc.)

Nervous system (cerebral palsy, seizures, autism)

Eye, ears, nose, throat (allergies, nasal polyps, tumors, surgeries)

Breathing (asthma, cystic fibrosis, bronchopulmonary dysplasia)

Cardiac (congenital heart disease, any heart surgery)

Gastrointestinal (heartburn, ulcers, swallowing difficulties, diarrhea, constipation, food intolerance)

Urinary or kidney (infections, stones, cancers)

Endocrine (diabetes, thyroid problems, use of steroids)

Blood (anemia, leukemia, lymphoma, sickle cell)

Chronic pain (arthritis, back pain)

Please add any other comments that you think might be important.