PEDIATRIC SLEEP QUESTIONNAIRE

NAME:_____ DOB:_____

Please briefly describe the current sleep problem or reason for sleep referral:

_____

_____

_____

Have you ever had a sleep study in the past? Yes or No If so, when and where_____

PLEASE CHECK ANY CURRENT SLEEP PROBLEM:

__Snoring

__pauses in breathing in sleep

__excessive daytime sleepiness

__dry throat/mouth upon awakening

__headache upon awakening

__sleep maintenance insomnia

__sleep onset insomnia

__frequent throat infections

__nightmares

__sleepwalking

__bedwetting

__night terrors

__acting out dreams

__leg kicking in sleep

__fragmented or restless sleep

__nasal congestion

__sudden loss of muscle strength associated with change in emotion.

Sleep transition object (teddy bear, stuffed animal, blanket) : _____
Requires co-sleeping with parents for sleep onset: ____YES ____NO
Autism spectrum disorders ____ YES ____NO
Behavioral issues - ADD, ADHD, ODD, Impulse control: ___YES ___NO

How long does it take to fall asleep: _____ ***Is patient feeling refreshed upon awakening? YES or NO***

Usual school night bedtime:_____ ***Usual school night wake time:_____***

Usual weekend/holiday bedtime:_____ ***Usual weekend/holiday wake time:_____***

Any naps? (frequency and time spent)_____

MEDICAL HISTORY

_____
_____
_____
_____
_____

SURGICAL HISTORY

_____
_____
_____
_____
_____

Have you had your tonsils and/or adenoids removed: yes or no

Patient name : _____ DOB: _____

School History:

Child's current grade level? _____

Current grades vs. previous years: ☐ better ☐ worse ☐ same

Any teacher/school reports about child? ☐ YES ☐ NO

If yes, describe here:

_____

_____

Does your child get along well with other kids? ☐ YES ☐ NO

Any developmental delay or special education? ☐ YES ☐ NO

Was the child ever left back a grade? ☐ YES ☐ NO

Current Medications:

_____

_____

_____

_____

_____

_____

Allergies:

_____

_____

_____

_____

_____

_____

Please check any current symptoms/issues you are having:

General: ☐ weight gain ☐ weight loss

Skin: ☐ rash ☐ itching

Nose/sinuses/throat: ☐ nasal congestion ☐ runny nose ☐ post-nasal drip ☐ sore throat

Eyes: ☐ blurry vision ☐ eye pain ☐ eye redness

Cardiac: ☐ chest pain ☐ heart palpitations

Respiratory: ☐ cough ☐ shortness of breath ☐ wheezing

GI: ☐ heartburn ☐ reflux ☐ nausea ☐ vomiting ☐ diarrhea ☐ constipation

Urinary: ☐ difficulty urinating (dysuria) ☐ frequent urination

Musculoskeletal: ☐ muscle aches ☐ back pain ☐ joint pain

Allergies: ☐ food ☐ medication ☐ environmental allergies

Neurologic: ☐ seizures ☐ headaches

Psychiatric: ☐ depression ☐ anxiety

Riverside MEDICAL GROUP
SLEEP MEDICINE

EPWORTH SLEEPINESS SCALE FOR CHILDREN AND ADOLESCENTS(CHAD) **(12-17 YRS AND OVER)**

Name: _____ Today's date: _____Age: _____

The scale helps measure your child's daytime sleepiness level. Please assist your child with the following questions.

Use the following scale to choose the **most appropriate number** for each situation. **It is important that you answer each question as best you can.**

0 = would **never** doze/fall asleep
1 = ***slight chance*** *of dozing/falling asleep*
2 = ***moderate chance*** *of dozing/falling asleep*
3 = ***high chance*** *of dozing/falling asleep*

How likely are you to doze off or fall asleep in the following situations:

Situation:	**Chance of Dozing (0-3):**
Sitting and reading	_____
Watching TV or video	_____
Sitting in a classroom at school during the morning	_____
Sitting and riding in a car/bus for about half an hour	_____
Lying down to rest or nap in the afternoon	_____
Sitting and talking to someone	_____
Sitting quietly by yourself after a lunch	_____
Sitting and eating a meal	_____
Total:	_____