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Sleep Center

NEW PATIENT – PEDIATRIC SLEEP QUESTIONNAIRE

Please answer each question and bring the completed questionnaire to your child's sleep study.
Note that page 6 (Sleep Diary) requires daily entries for a two week period.

PATIENT INFORMATION

Patient Name:	**Today's Date:**
Date of Birth:	**Gender:** ☐ M ☐ F
Age:	**Referring Provider:**
Parent / Caregiver Name:	

MEASUREMENTS

Height:	**ft**	**in**	**BMI:**	**kg/m2**
Weight:	**lbs**			

CHIEF COMPLAINT

What is the reason for your child's visit today?

Duration of complaint: ____ Weeks ____ Months ____ Years

BEARS[1] (Age 5 and Under) To be completed by Parent	**YES**	**NO**
Does your child have any problems going to bed or falling asleep?	☐	☐
Does your child seem overtired or sleepy a lot during the day?	☐	☐
Does he/she still take naps?	☐	☐
Does your child wake up a lot at night?	☐	☐
Does your child have a regular bedtime and wake time?	☐	☐
Does your child have loud snoring or breathing difficulties at night?	☐	☐

BEARS[1] (Age 6-12 years) To be completed by Parent and Patient	**YES**	**NO**
Does your child have any problems at bedtime?	☐	☐
Does your child have difficulty waking in the morning/seem sleepy during the day?	☐	☐
Does your child seem to wake up a lot at night?	☐	☐
Does your child sleepwalk?	☐	☐
Does your child have nightmares?	☐	☐
Does your child have loud or nightly snoring?	☐	☐
Does your child have difficulties breathing at night?	☐	☐

Patient Name: _____ **DOB:** _____

BEARS[1] **(Age 13-18 years) To be completed by Patient**	**YES**	**NO**
Do you have any problems following asleep?	☐	☐
Do you feel sleepy a lot during the day?	☐	☐
Do you feel sleep a lot in school?	☐	☐
Do you feel sleepy while driving? (if applicable)	☐	☐
Do you wake up a lot at night?	☐	☐
Do you have trouble getting back to sleep after waking in the middle of the night?	☐	☐
Do you or have you been told you snore loudly or nightly?	☐	☐

PEDIATRIC DAYTIME SLEEPINESS SCALE[2]

Please check **THE MOST APPROPRIATE NUMBER** for each situation.
(If age < 11 yrs, then disregard first two questions)
4= ALWAYS / 3= FREQUENTLY / 2= SOMETIMES / 1= SELDOM / 0= NEVER

How often do you fall asleep/get drowsy during class?	☐ **4**	☐ **3**	☐ **2**	☐ **1**	☐ **0**
How often do you get sleepy doing homework?	☐ **4**	☐ **3**	☐ **2**	☐ **1**	☐ **0**
Are you usually alert during most of the day?	☐ **4**	☐ **3**	☐ **2**	☐ **1**	☐ **0**
How often are you tired and/or grumpy during the day?	☐ **4**	☐ **3**	☐ **2**	☐ **1**	☐ **0**
How often do you have trouble getting out of bed in the morning?	☐ **4**	☐ **3**	☐ **2**	☐ **1**	☐ **0**
How often do you fall asleep after being awakened in the morning?	☐ **4**	☐ **3**	☐ **2**	☐ **1**	☐ **0**
How often do you need someone to awaken you in the morning?	☐ **4**	☐ **3**	☐ **2**	☐ **1**	☐ **0**
How often do you think that you need more sleep?	☐ **4**	☐ **3**	☐ **2**	☐ **1**	☐ **0**
	Total Score =				

SLEEP QUALITY ASSESSMENT

Average Bedtime?	**Weekday:** ☐ **AM** ☐ **PM**	**Weekend:** ☐ **AM** ☐ **PM**	
Average Wake time?	**Weekday:** ☐ **AM** ☐ **PM**	**Weekend:** ☐ **AM** ☐ **PM**	
When you go to bed, how long does it usually take to fall asleep?		☐ **min** ☐ **hrs**	
How many times do you awaken on an average night?	**times**		
Does the patient take naps during the day?			☐ **YES** ☐ **NO**
How many naps?	How long are the naps?		☐ **min** ☐ **hrs**
Does the patient have dreams?			☐ **YES** ☐ **NO**
Does the patient have nightmares?			☐ **YES** ☐ **NO**
Does the patient have limb jerks at night?			☐ **YES** ☐ **NO**
Does the patient grind his/her teeth during sleep?			☐ **YES** ☐ **NO**
Does the patient have any unusual sleep behavior (e.g. sleepwalking/sleep talking)?			☐ **YES** ☐ **NO**
Does the patient ever awaken from sleep with a feeling of muscular paralysis?			☐ **YES** ☐ **NO**
Has the patient ever developed muscle weakness or paralysis during wakefulness?			☐ **YES** ☐ **NO**
Does the patient have episodes of bedwetting?			☐ **YES** ☐ **NO**
At night, does the patient usually get out of bed to urinate?			☐ **YES** ☐ **NO**

Patient Name: _____ **DOB:** _____

SLEEP MEDICINE HISTORY

Has the Patient ever had a sleep study? ☐ **YES** ☐**NO**	When?	Where?
Results of sleep study:		

MEDICAL HISTORY

Please list all medical conditions.

SURGICAL HISTORY

Please list all surgeries.

MEDICATIONS

MEDICATIONS (attach list if necessary)			**SLEEPING PILLS / STIMULANTS**		
Medication	**Dose**	**Frequency**	**Medication**	**Dose**	**Frequency**
			DRUG ALLERGIES		
			Medication	**Reaction**	

FAMILY HISTORY

Mother	☐ Alive (current age: yrs)	☐ Deceased (at age: yrs)
	Medical Problems:	
Father	☐ Alive (current age: yrs)	☐ Deceased (at age: yrs)
	Medical Problems:	
Siblings	#:	Ages:
	Medical Problems:	
Other Pertinent Family History:		

SOCIAL HISTORY

With whom does the patient reside?	☐ Father ☐ Mother ☐ Both ☐ Other
Does anyone in the home smoke?	☐ Yes ☐ No
Does the child attend daycare/school?	☐ Yes ☐ No
Overall school performance:	☐ At grade level ☐ Above grade ☐ Below grade
Exercise/ sports _____ hours/ day	

Patient Name: _____ **DOB:** _____

REVIEW OF SYSTEMS

Please indicate whether you have experienced any of the following symptoms:

	Now	Prior	Never
GENERAL			
Fever			
Chills			
Night Sweats			
Recent Weight Loss (___lbs.)			
Recent Weight Gain (___lbs.)			
Loss of Appetite			
Feeling Tired (Fatigue)			
Eczema			
Developmental Delays			
LUNGS / CHEST			
Coughing			
Wheezing			
Difficulty Breathing at Rest			
Difficulty Breathing with Exertion			
Coughing Mucous			
STOMACH / BOWEL			
Abdominal Pain			
Nausea			
Vomiting			
Diarrhea			
Acid Reflux			
Constipation			
Bowel/Bladder Changes			
EAR / NOSE / THROAT			
Frequent ear infections			
PE Tubes			
Squinting			
Eye Pain			
Mouth Breathing			
Loss of Hearing			
Nasal passage blockage (stuffiness)			
Sore Throat			
Difficulty Swallowing			

	Now	Prior	Never
LYMPH NODES			
Swollen Glands in Neck			
Groin Lymph Node Swelling			
NERVES AND BRAIN			
Headache			
Convulsions/Seizures			
Limb Weakness			
Numbness/Tingling			
MUSCLE / BONES / JOINTS			
Muscle Aches			
Joint Swelling			
Bone Pain			
BEHAVIORAL			
Attention Difficulties			
Aggressiveness			
Tantrums			
Problems in School			
History Psychological Problems			
ENDOCRINE			
Hot/Cold Intolerance			
Excessive Thirst/Fluid Intake			
GENITOURINARY			
Frequent, Full Bladder Emptying			
Pain During Urination			
Bloody urine			
Increased Frequency			
Bed Wetting			
SLEEP			
Excessive Sleepiness			
Insomnia			
Snoring			
Stop Breathing at Night			

REFERENCES

1) "A Clinical Guide to Pediatric Sleep: Diagnosis and Management of Sleep Problems" by Jodi A. Mindell and Judith A. Owens; Lippincott Williams & Wilkins
2) Drake C, Nickel C, Burduvali E et al. The pediatric daytime sleepiness scale (PDSS): sleep habits and school outcomes in middle school children. *SLEEP* 2003;26(4):455-458.

Patient Name: _____ **DOB:** _____

TWO WEEK SLEEP DIARY

INSTRUCTIONS:

1. Write the date, day of the week, and type of day: Work, School, Day Off, or Vacation.
2. Put the letter "C" in the box when you have coffee, cola or tea. Put "M" when you take any medicine. Put "A" when you drink alcohol. Put "E" when you exercise.
3. Put a line (|) to show when you go to bed. Shade in the box that shows when you think you fell asleep.
4. Shade in all the boxes that show when you are asleep at night or when you take a nap during the day.
5. Leave boxes unshaded to show when you wake up at night and when you are awake during the day.

SAMPLE ENTRY BELOW: On a Monday when I worked, I jogged on my lunch break at 1 PM, had a glass of wine with dinner at 6 PM, fell asleep watching TV from 7 to 8 PM, went to bed at 10:30 PM, fell asleep around Midnight, woke up and couldn't get back to sleep at about 4 AM, went back to sleep from 5 to 7 AM, and had coffee and medicine at 7:00 in the morning.

Today's Date	Day of the week	Type of Day Work, School, Off, Vacation	
sample	Mon.	Work	Noon
			1PM
		E	2
			3
			4
			5
			6PM
		A	7
			8
			9
			10
		I	11PM
			Midnight
			1AM
			2
			3
			4
			5
			6AM
		C M	7
			8
			9
			10
			11AM

week 1

week 2