



Pediatric Sleep History Questionnaire

Welcome to Sleep Center Hawaii! Filling out this questionnaire will help our sleep specialist focus on your child's specific sleep problem. Thank you for your cooperation!

PATIENT NAME: _____

PARENT/GUARDIAN COMPLETING QUESTIONNAIRE: _____

PHONE NO: DAY: _____ EVENINGS: _____

AGE: _____ SEX: _____ HEIGHT: _____ WEIGHT: _____

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? _____ Results: _____

Weekly Sleep Schedule

How many naps does your child take during the day?		Length of naps?	
Child's usual bedtime on weekdays?		Child's usual bedtime on weekends?	
Child's usual wake time on weekdays?		Child's usual wake time on weekends?	

Amount of time your child sleeps during a 24-hour period on weekdays (Add Daytime And Nighttime Sleep):

_____ hours _____ minutes

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 their own room? No Yes
5. Is your child able to fall asleep on their own? No Yes
6. Does your child wake during the night?
 - a. If yes, how many times? _____
7. 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 | <input type="checkbox"/> 0 | <input type="checkbox"/> 1-2 | <input type="checkbox"/> 3-4 | <input type="checkbox"/> 5-6 | <input type="checkbox"/> Every Night |
| 2. Stops breathing during sleep | <input type="checkbox"/> 0 | <input type="checkbox"/> 1-2 | <input type="checkbox"/> 3-4 | <input type="checkbox"/> 5-6 | <input type="checkbox"/> Every Night |
| 3. Snores or noisy breathing while asleep | <input type="checkbox"/> 0 | <input type="checkbox"/> 1-2 | <input type="checkbox"/> 3-4 | <input type="checkbox"/> 5-6 | <input type="checkbox"/> Every Night |
| 4. Turns pale or blue during sleep | <input type="checkbox"/> 0 | <input type="checkbox"/> 1-2 | <input type="checkbox"/> 3-4 | <input type="checkbox"/> 5-6 | <input type="checkbox"/> Every Night |
| 5. Restless sleep/Tossing and turning | <input type="checkbox"/> 0 | <input type="checkbox"/> 1-2 | <input type="checkbox"/> 3-4 | <input type="checkbox"/> 5-6 | <input type="checkbox"/> Every Night |
| 6. Sweating while sleeping | <input type="checkbox"/> 0 | <input type="checkbox"/> 1-2 | <input type="checkbox"/> 3-4 | <input type="checkbox"/> 5-6 | <input type="checkbox"/> Every Night |
| 7. Daytime sleepiness/Naps after school | <input type="checkbox"/> 0 | <input type="checkbox"/> 1-2 | <input type="checkbox"/> 3-4 | <input type="checkbox"/> 5-6 | <input type="checkbox"/> Every Night |
| 8. Falls asleep in school | <input type="checkbox"/> 0 | <input type="checkbox"/> 1-2 | <input type="checkbox"/> 3-4 | <input type="checkbox"/> 5-6 | <input type="checkbox"/> Every Night |
| 9. Poor appetite | <input type="checkbox"/> 0 | <input type="checkbox"/> 1-2 | <input type="checkbox"/> 3-4 | <input type="checkbox"/> 5-6 | <input type="checkbox"/> Every Night |
| 10. Nightmares/Night terrors | <input type="checkbox"/> 0 | <input type="checkbox"/> 1-2 | <input type="checkbox"/> 3-4 | <input type="checkbox"/> 5-6 | <input type="checkbox"/> Every Night |
| 11. Sleep talks | <input type="checkbox"/> 0 | <input type="checkbox"/> 1-2 | <input type="checkbox"/> 3-4 | <input type="checkbox"/> 5-6 | <input type="checkbox"/> Every Night |
| 12. Kicks or moves arms/legs during sleep | <input type="checkbox"/> 0 | <input type="checkbox"/> 1-2 | <input type="checkbox"/> 3-4 | <input type="checkbox"/> 5-6 | <input type="checkbox"/> Every Night |
| 13. Wets the bed | <input type="checkbox"/> 0 | <input type="checkbox"/> 1-2 | <input type="checkbox"/> 3-4 | <input type="checkbox"/> 5-6 | <input type="checkbox"/> Every Night |
| 14. Creepy-crawly/uncomfortable feeling in legs | <input type="checkbox"/> 0 | <input type="checkbox"/> 1-2 | <input type="checkbox"/> 3-4 | <input type="checkbox"/> 5-6 | <input type="checkbox"/> Every Night |
| 15. Resists going to bed | <input type="checkbox"/> 0 | <input type="checkbox"/> 1-2 | <input type="checkbox"/> 3-4 | <input type="checkbox"/> 5-6 | <input type="checkbox"/> Every Night |
| 16. Wakes up at night | <input type="checkbox"/> 0 | <input type="checkbox"/> 1-2 | <input type="checkbox"/> 3-4 | <input type="checkbox"/> 5-6 | <input type="checkbox"/> Every Night |
| 17. Gets out of bed at night | <input type="checkbox"/> 0 | <input type="checkbox"/> 1-2 | <input type="checkbox"/> 3-4 | <input type="checkbox"/> 5-6 | <input type="checkbox"/> Every Night |
| 18. Grinds teeth while asleep | <input type="checkbox"/> 0 | <input type="checkbox"/> 1-2 | <input type="checkbox"/> 3-4 | <input type="checkbox"/> 5-6 | <input type="checkbox"/> Every Night |
| 19. Trouble getting up in the morning | <input type="checkbox"/> 0 | <input type="checkbox"/> 1-2 | <input type="checkbox"/> 3-4 | <input type="checkbox"/> 5-6 | <input type="checkbox"/> Every Night |
| 20. Sees frightening images before falling asleep | <input type="checkbox"/> 0 | <input type="checkbox"/> 1-2 | <input type="checkbox"/> 3-4 | <input type="checkbox"/> 5-6 | <input type="checkbox"/> Every Night |
| 21. Feels weak or loses control of muscles suddenly with strong emotions (laughter, anger, crying, etc.) while awake | <input type="checkbox"/> 0 | <input type="checkbox"/> 1-2 | <input type="checkbox"/> 3-4 | <input type="checkbox"/> 5-6 | <input type="checkbox"/> Every Night |
| 22. Screaming in sleep | <input type="checkbox"/> 0 | <input type="checkbox"/> 1-2 | <input type="checkbox"/> 3-4 | <input type="checkbox"/> 5-6 | <input type="checkbox"/> Every Night |

Past Medical History

- | | | | |
|-------------------------------------------------|-----------------------------|------------------------------|--------------------|
| 1. Frequent nasal congestion/Sinus problems | <input type="checkbox"/> No | <input type="checkbox"/> Yes | If Yes, Age: _____ |
| 2. Trouble breathing through nose | <input type="checkbox"/> No | <input type="checkbox"/> Yes | If Yes, Age: _____ |
| 3. Enlarged tonsils/Enlarged adenoids | <input type="checkbox"/> No | <input type="checkbox"/> Yes | If Yes, Age: _____ |
| 4. Chronic cough/Bronchitis | <input type="checkbox"/> No | <input type="checkbox"/> Yes | If Yes, Age: _____ |
| 5. Allergies | <input type="checkbox"/> No | <input type="checkbox"/> Yes | If Yes, Age: _____ |
| 6. Asthma | <input type="checkbox"/> No | <input type="checkbox"/> Yes | If Yes, Age: _____ |
| 7. Frequent colds or flu | <input type="checkbox"/> No | <input type="checkbox"/> Yes | If Yes, Age: _____ |
| 8. Frequent strep throat | <input type="checkbox"/> No | <input type="checkbox"/> Yes | If Yes, Age: _____ |
| 9. Had tonsils out | <input type="checkbox"/> No | <input type="checkbox"/> Yes | If Yes, Age: _____ |
| 10. Frequent ear infections | <input type="checkbox"/> No | <input type="checkbox"/> Yes | If Yes, Age: _____ |
| 11. Ear tubes placed | <input type="checkbox"/> No | <input type="checkbox"/> Yes | If Yes, Age: _____ |
| 12. Difficulty swallowing | <input type="checkbox"/> No | <input type="checkbox"/> Yes | If Yes, Age: _____ |
| 13. Acid reflux/GERD | <input type="checkbox"/> No | <input type="checkbox"/> Yes | If Yes, Age: _____ |
| 14. Poor or delayed growth | <input type="checkbox"/> No | <input type="checkbox"/> Yes | If Yes, Age: _____ |
| 15. Excessive weight | <input type="checkbox"/> No | <input type="checkbox"/> Yes | If Yes, Age: _____ |
| 16. Neurologic or muscular disorder | <input type="checkbox"/> No | <input type="checkbox"/> Yes | If Yes, Age: _____ |
| 17. Cerebral Palsy | <input type="checkbox"/> No | <input type="checkbox"/> Yes | If Yes, Age: _____ |
| 18. Seizure/Epilepsy | <input type="checkbox"/> No | <input type="checkbox"/> Yes | If Yes, Age: _____ |
| 19. Morning headaches | <input type="checkbox"/> No | <input type="checkbox"/> Yes | If Yes, Age: _____ |
| 20. Chromosomal disorder (e.g. Down's syndrome) | <input type="checkbox"/> No | <input type="checkbox"/> Yes | If Yes, Age: _____ |
| 21. Skeleton problems (e.g. Dwarfism) | <input type="checkbox"/> No | <input type="checkbox"/> Yes | If Yes, Age: _____ |
| 22. Genetic disorder | <input type="checkbox"/> No | <input type="checkbox"/> Yes | If Yes, Age: _____ |
| 23. Craniofacial disorder (e.g. Pierre-Robin) | <input type="checkbox"/> No | <input type="checkbox"/> Yes | If Yes, Age: _____ |
| 24. Thyroid problems | <input type="checkbox"/> No | <input type="checkbox"/> Yes | If Yes, Age: _____ |
| 25. Pain | <input type="checkbox"/> No | <input type="checkbox"/> Yes | If Yes, Age: _____ |
| 26. Meningitis | <input type="checkbox"/> No | <input type="checkbox"/> Yes | If Yes, Age: _____ |
| 27. Autism | <input type="checkbox"/> No | <input type="checkbox"/> Yes | If Yes, Age: _____ |
| 28. Developmental Delay | <input type="checkbox"/> No | <input type="checkbox"/> Yes | If Yes, Age: _____ |
| 29. Hyperactivity/ADHD | <input type="checkbox"/> No | <input type="checkbox"/> Yes | If Yes, Age: _____ |
| 30. Anxiety/Panic Attacks | <input type="checkbox"/> No | <input type="checkbox"/> Yes | If Yes, Age: _____ |
| 31. Obsessive Compulsive Disorder | <input type="checkbox"/> No | <input type="checkbox"/> Yes | If Yes, Age: _____ |
| 32. Depression | <input type="checkbox"/> No | <input type="checkbox"/> Yes | If Yes, Age: _____ |
| 33. Suicidal Ideation | <input type="checkbox"/> No | <input type="checkbox"/> Yes | If Yes, Age: _____ |
| 34. Learning disabilities | <input type="checkbox"/> No | <input type="checkbox"/> Yes | If Yes, Age: _____ |
| 35. Drug use/abuse | <input type="checkbox"/> No | <input type="checkbox"/> Yes | If Yes, Age: _____ |
| 36. Behavioral disorder | <input type="checkbox"/> No | <input type="checkbox"/> Yes | If Yes, Age: _____ |
| 37. Psychiatric admission | <input type="checkbox"/> No | <input type="checkbox"/> Yes | If Yes, Age: _____ |

Birth History:

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

Please list any hospitalizations, surgeries, or other medical diagnosis your child has had below:

Does your child take any medications? No Yes

If yes, please list names, dosage, and reason for taking them:

NAME	DOSAGE/FREQUENCY	REASON TAKEN

Does anyone in your family (blood relatives only) have a history of any of the following sleep problems? (Please checkmark and indicate who):

- | | | | |
|--------------------------------------------|-----------------------------|------------------------------|-----------------|
| 1. Insomnia (Inability To Fall Asleep) | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Relation: _____ |
| 2. Sleep Apnea | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Relation: _____ |
| 3. Restless Leg Syndrome | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Relation: _____ |
| 4. Periodic Limb Movements in Sleep (PLMS) | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Relation: _____ |
| 5. Sleepwalking/sleep terrors | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Relation: _____ |
| 6. Sleep talking | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Relation: _____ |
| 7. Narcolepsy (inability to stay awake) | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Relation: _____ |
| 8. Snoring | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Relation: _____ |

School Performance (If of school age)

- | | | | | | |
|-------------------------------------------------------------------------|-----------------------------|------------------------------|---------|------|---------|
| 1. Have you noticed a recent change in your child's school performance? | <input type="checkbox"/> No | <input type="checkbox"/> Yes | | | |
| 2. What grade is your child in? | _____ | | | | |
| 3. Has your child ever repeated a grade?
if yes, what grade(s)? | <input type="checkbox"/> No | <input type="checkbox"/> Yes | | | |
| 4. Is your child enrolled in any special education classes? | <input type="checkbox"/> No | <input type="checkbox"/> Yes | | | |
| 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? | _____ | | | | |
| 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 |

What does your child like to do in their spare time (Hobbies, Crafts, Organizations, Clubs, and Sports)? Please List:

Does anyone in the house smoke? No Yes

How much of the following beverages containing caffeine does your child drink in an average 24-hour period?

Coffee _____ Tea _____ Coca-Cola/Soda _____

Please add any comments or problems not listed in this questionnaire:

Thank You For Completing Our Questionnaire!