St. Luke’s Sleep Medicine Institute

PEDIATRIC SLEEP QUESTIONNAIRE

Name: _________________________________________       Age:  ___________       Today's Date:  ______________

Referring Physician: _______________________________       Sleep Physician:  _______________________________

Child's Date of Birth:  ______________________________       Child's Weight:     ______________________________

SLEEP COMPLAINT:
Please explain what you feel is your child's main sleep problem(s):___________________________________________
__________________________________________________________________  ______________________________

How long has the child had this problem?    ________________________
Do you feel it is:  getting worse [    ]  staying the same  [    ]  getting better  [    ]

What is your child's normal bedtime?   _______________     What time does he usually wake up?   ______________

Please check all that applies to your child:
30 minutes before bedtime, does your child…
[    ] Read
[    ] Watch TV
[    ] Play on the computer
[    ] Other:  ____________________________________________________________________________________

The following questions relate to how your child falls asleep:
[    ] Does your child fall asleep alone in bed?
[    ] Does your child need a special toy or object to fall asleep?  If so, describe: _______________________________
________________________________________________________________________________________________

[    ] Does your child need to nurse, or have a bottle to fall asleep?
[    ] Does your child sleep alone?  If not, who do they sleep with? _________________________________________
________________________________________________________________________________________________

[    ] Does your child sleep in a crib?
[    ] Does your child sleep in a bed?
[    ] Does your child cry himself to sleep?  If so, how many times each week? ________________________________
How long does it take your child to fall asleep? __________  minutes  __________ hours
Does your child have any of the following behaviors?

[ ] restless sleep
[ ] sleep walking
[ ] leg pain, jerking or restless legs
[ ] bed wetting
[ ] snoring, or loud breathing
[ ] sleeping with their head arched back or in an unusual sleep position (explain) _____________________________
__________________________________________________________________________________________

Does your child do anything else notable or concerning to you during the night?
__________________________________________________________________________________________
__________________________________________________________________________________________

While sleeping, does your child ...

[ ] snore more than half of the time?
[ ] always snore?
[ ] snore loudly?
[ ] have "heavy" or loud breathing?
[ ] have trouble breathing, or struggles to breathe?
[ ] Have you seen your child stop breathing during the night?
[ ] Does your child wake up during the night? If so, how many times? ______________________

When your child wakes up ...

[ ] Does he get up on his own? What time? ______________
[ ] Do you have trouble waking him? How long does it take? __________________________
[ ] Does your child seem alert and happy when waking?
[ ] Is your child "cranky" or sluggish when waking?
   Explain how your child typically feels when waking in the morning. __________________________
__________________________________________________________________________________________

During the day, does your child ...

[ ] Feel sleepy?
[ ] Take a nap? How many each day? ___________ How long does he sleep? ___________
[ ] Have others (teachers/friends/family) commented on your child's daytime sleepiness?
[ ] Can your child breathe through his nose, or does he breathe through his mouth during the day?
[ ] Does your child seem not to listen when spoken to directly?
[ ] Does he have difficulty organizing tasks and activities?
[ ] Is your child easily distracted by extraneous stimuli?
[ ] Would you say your child is hyperactive?
[ ] Have others (teachers/friends/family) commented on your child's daytime hyperactivity/behavior?
[ ] Does your child have behavior problems at home or at school?
   If so, describe his behavior: __________________________
__________________________________________________________________________________________

2
Medications:

Please list all medications the child is currently taking:

_________________________________  __________________________________________

_________________________________  __________________________________________

List any allergies your child has:

_________________________________  __________________________________________

Diet:

How much caffeine (sodas, cocoa, chocolate drinks, tea or coffee) does the child drink or eat each day?

Number of cans, cups or glasses _____________ Chocolate candy, ice cream, cookies etc. _____________

History:

List any serious illnesses, birth defects, operations, or injuries:

_________________________________  __________________________________________

_________________________________  __________________________________________

[ ] Was your child born prematurely. If so, how early? _____________

[ ] Has your child been diagnosed with a thyroid problem?

[ ] Does your child have high blood pressure?

[ ] Does your child have hay-fever type allergies?

[ ] Has your child been diagnosed with asthma?

[ ] Has your child had his tonsils removed?

[ ] Has your child had his adenoids removed?

[ ] Does your child ever smoke cigarettes?

[ ] Is your child exposed to cigarette smoke in the home?

_________________________________  __________________________________________

Name of Person Completing Information  Relationship to Child

Pediatric Questionnaire
Rev. 06/2004