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: _____

_____

_____

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
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