sleephealth
clinic of The Woodlands

8505 Technology Forest Place, Suite 1002
The Woodlands, TX 77381

Phone: (936) 273-9311 Fax: (877) 545-2384

E-Mail: info@sleephealthwoodlands.com
Web: www.sleephealthwoodlands.com

CONFIDENTIAL PEDIATRIC PATIENT QUESTIONNAIRE

Name of Patient:_____ Date:_____ Date of Birth:_____

Name of Person Completing Questionnaire:_____ Relationship:_____

Referral Source:_____

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Previous PSG?
Y N

What is your primary concern/problem regarding your child's sleep?

_____

_____

_____

How long has your child had this problem? _____

Not including your child's primary care physician or referring doctor, has your child seen another doctor for your sleep problem? ❒ Yes ❒ No

If yes, who was the doctor and when was your child seen?

_____

_____

If yes, what was the diagnosis? _____

Did your child have a sleep study? ❒ Yes ❒ No
If yes, when and where? _____

_____

What treatment, if any, was recommended? _____

_____

Was the treatment effective? ❒ Yes ❒ No

Do you have any allergies or reactions to drugs? ❒ Yes ❒ No

If yes, specify drug and reaction: _____

_____

_____

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Medical History

Check the appropriate boxes if your child has or has had any of the following conditions:

- ❒ Allergies
- ❒ Anemia/blood disease
- ❒ Anxiety
- ❒ Arthritis
- ❒ Asthma
- ❒ ADHD or ADD
- ❒ Cancer
- ❒ Depression
- ❒ Developmental delay
- ❒ Diabetes (Type I/II)
- ❒ Other Lung Disease
- ❒ Ulcers/intestinal disease
- ❒ Heartburn/acid reflux
- ❒ Heart disease
- ❒ High blood pressure
- ❒ High cholesterol/triglycerides
- ❒ Kidney/bladder disease
- ❒ Liver disease
- ❒ Learning disorder
- ❒ Neurologic disease
- ❒ Seizures
- ❒ Sinusitis
- ❒ Thyroid disease (Hyper- or Hypo-)
- ❒ Other

_____
_____
_____

Has your child had his/her tonsils removed? ❒ Yes ; At what age? ____ ❒ No

Has your child had nose or throat surgery? ❒ Yes; At what age? _____ ❒ No

Please list any other surgeries and/or hospitalization you have had:

Date	Reason

(If more spaces is needed, please continue on the back of this page)

Family History

Check the appropriate boxes if your family members have had any of the following conditions:

Medical N Y	Father	Mother	Siblings	Children
Cancer	❒	❒	❒	❒
Depression	❒	❒	❒	❒
Diabetes	❒	❒	❒	❒
Heart disease	❒	❒	❒	❒
High blood pressure	❒	❒	❒	❒
Stroke	❒	❒	❒	❒
Sleep N Y				
Insomnia	❒	❒	❒	❒
Narcolepsy	❒	❒	❒	❒
Restless legs	❒	❒	❒	❒
Sleep apnea	❒	❒	❒	❒
Snoring	❒	❒	❒	❒

Social History

Child lives with: ❒ both parents ❒ mother ❒ father ❒ other (please explain)

_____

Siblings (with ages): _____

_____

Where does your child sleep? _____

_____

Grade Level in school: _____ Special education? ❒ Yes ❒ No

Report card grades in school: ❒ Excellent ❒ Above average ❒ Struggling

Tobacco

Is the child exposed to cigarette smoke? ❒ Yes ❒ No/never ❒ No/stopped

Where and by whom? _____

Caffeine

Does your child drink caffeinated beverages? ❒ Yes ❒ No

If yes, _____ # of cans of soft drinks daily

_____ # of cups of coffee daily

_____ # of cups/glasses of tea daily

_____ # of cups/glasses of cocoa/chocolate milk daily

_____ # cans of energy drinks daily

Weight Status

Child's current weight: _____ Height: _____

Does your child get exercise:

❒ at school? If yes, # hours per week: _____

❒ at home? If yes, # hours per week: _____

Please describe activities: _____

❒ Other: _____

_____

_____

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Mood

Do you think your child is depressed? ❒ Yes ❒ No

If yes, ❒ rarely ❒ occasionally ❒ frequently

Would you describe your child as a worrier? ❒ Yes ❒ No

If yes, ❒ rarely ❒ occasionally ❒ frequently

Would you describe your child as irritable? ❒ Yes ❒ No

If yes, ❒ rarely ❒ occasionally ❒ frequently

Do you feel your child has had a recent personality change? ❒ Yes ❒ No

If yes, specify: _____

_____

_____

On school days:
Bedtime: _____ a.m./p.m. Wake time: _____ a.m./p.m.

On weekend/days off:
Bedtime: _____ a.m./p.m. Wake time: _____ a.m./p.m.

Scheduled naps? ❒ Yes ❒ No
If yes, list nap times and duration: _____

_____

Does your child appear refreshed after naps? ❒ Yes ❒ No

Does your child fall asleep outside of scheduled nap times? ❒ Yes ❒ No
If yes, when?_____

_____

Does your child have any of the following items in his/her bedroom?
❒ TV ❒ computer ❒ video games ❒ phone

Does your child share his/her bedroom with another person and/or pets?

❒ Yes ❒ No If yes, please specify: _____

_____

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Insomnia

Do your child have difficulty falling asleep? ❒ Yes ❒ No

If yes, how long does it take? _____ # minutes/hours ____# of nights weekly

How many times does your child awaken during the night?

If yes, _____ # of times nightly _____ # of nights weekly

Why does your child awaken? _____

_____

Does he/she return to sleep quickly? ❒ Yes ❒ No

Is your child awake for extended periods during the night?

❒ Yes ❒ No If yes, _____ # minutes/hours _____ # of nights weekly

Does your child wake too early in the morning and stay awake? ❒ Yes ❒ No

If yes, at what time?_____ a.m. _____ # of times weekly

Some of the following questions will ask you to rate the frequency of certain symptoms. If you check yes to any of the boxes, please use the scale below as a guide when answering the questions.

Frequently = 1 or more times per week
Occasionally = 1 or more times per month
Rarely = the issue occurs but it is less than the above

Does your child **currently**:

Have intense nightmares or night terrors? ❒ Yes ❒ No
If yes, ❒ rarely ❒ occasionally ❒ frequently

Grind or clinch your teeth at night? ❒ Yes ❒ No
If yes, ❒ rarely ❒ occasionally ❒ frequently

Talk in your sleep? ❒ Yes ❒ No
If yes, ❒ rarely ❒ occasionally ❒ frequently

Walk in your sleep? ❒ Yes ❒ No
If yes, ❒ with or ❒ without eating;
❒ rarely ❒ occasionally ❒ frequently

Have incontinence of urine during sleep? ❒ Yes ❒ No
If yes, ❒ rarely ❒ occasionally ❒ frequently

Please describe any unusual behaviors during sleep. _____

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Hypersomnia

Has your child ever been injured because of falling asleep during the day?
❒ Yes ❒ No If yes, when and please describe_____

_____

_____

Please circle the most accurate answer for the following questions:

How often does your child fall asleep or get drowsy during class?
0 = never 1 = seldom 2 = sometimes 3 = frequent 4 = always

How often does your child get sleepy while doing homework?
0 = never 1 = seldom 2 = sometimes 3 = frequent 4 = always

Is your child alert most of the day? (Please note number change.)
4 = never 3 = seldom 2 = sometimes 1 = frequent 0 = always

How often is your child tired and grumpy during the day?
0 = never 1 = seldom 2 = sometimes 3 = frequent 4 = always

How often does your child fall back asleep after being woken in the morning?
0 = never 1 = seldom 2 = sometimes 3 = frequent 4 = always

How often does your child need to be awakened by someone in the morning?
0 = never 1 = seldom 2 = sometimes 3 = frequent 4 = always

How often does your child think he/she needs more sleep?
0 = never 1 = seldom 2 = sometimes 3 = frequent 4 = always

Total = _____

Sleep Prl

Has your child ever felt unable to move (paralyzed) just as he/she was falling asleep or waking up? ❒ Yes ❒ No If yes, describe: _____

Cpxy

_____

Hh

Has your child ever appeared to suddenly experience muscle weakness or fallen down when laughing, being surprised, or getting angry? ❒ Yes ❒ No

If yes, describe: _____

_____

RO - Nar/MSLT

Has your child ever had <u>exceptionally</u> vivid dreams *as he/she was falling asleep or waking up*? ❒ Yes ❒ No If yes, describe: _____

_____

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PLMS

Does your child move excessively during sleep? ❒ Yes ❒ No

If yes, ❒ rarely ❒ occasionally ❒ frequently

Does your child awaken him/herself by kicking his/her legs? ❒ Yes ❒ No

If yes, ❒ rarely ❒ occasionally ❒ frequently

RLS

Does your child ever complain of discomfort in his or her legs that makes it difficult to fall asleep? ❒ Yes ❒ No

If yes, ❒ rarely ❒ occasionally ❒ frequently

If yes, describe:_____

OSAS

Does your child snore? ❒ Yes ❒ No ❒ Unknown

If yes, is it ❒ occasionally or ❒ continuously;

and is it ❒ only when sleeping on his/her back or ❒ in any position.

Indicate the severity of your child's snoring by using the scale below:

☐ Grade 1: Heard only if you listen close to the face

☐ Grade 2: Heard in the room

☐ Grade 3: Heard just outside the bedroom with the door open

☐ Grade 4: Heard outside the bedroom with the door closed

Have you witnessed your child stop breathing during sleep?

❒ Yes ❒ No If yes, ❒ rarely ❒occasionally ❒ frequently

Does your child wake gasping for air?

❒ Yes ❒ No If yes, ❒ rarely ❒occasionally ❒ frequently

Does your child wake with a dry mouth?

❒ Yes ❒ No If yes, ❒ rarely ❒occasionally ❒ frequently

Does your child wake with nasal congestion?

❒ Yes ❒ No If yes, ❒ rarely ❒occasionally ❒ frequently

Does your child wake with morning headaches?

❒ Yes ❒ No If yes, ❒ rarely ❒occasionally ❒ frequently

Does your child wake with a sore throat?

❒ Yes ❒ No If yes, ❒ rarely ❒occasionally ❒ frequently

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Does your child have night sweats?

❒ Yes ❒ No If yes, ❒ rarely ❒occasionally ❒ frequently

Does your child have heartburn at night?

❒ Yes ❒ No If yes, ❒ rarely ❒occasionally ❒ frequently

Does your child feel unrefreshed after sleeping?

❒ Yes ❒ No If yes, ❒ rarely ❒occasionally ❒ frequently

Does your child have problems with memory or concentration?

❒ Yes ❒ No If yes, ❒ rarely ❒occasionally ❒ frequently

Does your child appear to be confused in the morning?

❒ Yes ❒ No If yes, ❒ rarely ❒occasionally ❒ frequently

Does your child wake to urinate during the night?

❒ Yes ❒ No If yes, ❒ rarely ❒occasionally ❒ frequently

Please tell us if there are any other concerns that you have about your sleep that were not covered in the above questionnaire:

_____

_____

_____

Please email all initial paperwork to us at **info@sleephealthwoodlands.com** or fax to **1-877-545-2384** (toll free).

Thank you for taking the time to fill out this questionnaire.
We look forward to seeing you at your scheduled consultation.

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