SLEEP MEDICINE

1906 Blake Ave. Glenwood Springs, CO. 81601
Phone# 970-384-7694 Fax# 970-384-4202

PEDIATRIC QUESTIONNAIRE

CHILD'S FULL NAME:_____SSN:_____DATE:_____

AGE Years_____Months_____ HEIGHT_____ WEIGHT_____

*** Please complete this questionnaire and bring it with you on the night of your child's Sleep Study.**

Be as complete as possible in answering the questions below. The more information you give, the more complete the evaluation of your child's condition will be. If you need more room for your response(s), please use the back side of the page you are on.

Circle the most appropriate answers in the questionnaire.

DK means "Don't Know" **NA** means "Not Applicable"

If you have any specific questions or concerns, or if your child has any special needs, please call 580-821-5350 before the date of your child's study.

Who is completing this questionnaire?_____Relationship to child?_____

****

Please describe in your own words, as completely as possible, your child's main sleep problem.

_____

_____

_____

When did this problem first begin?_____

Do you consider your child's sleep problem to be: Mild _____ Moderate _____ Severe_____

List any medications that your child is ***currently*** taking to help with the sleep problem.

DRUG NAME AMOUNT TIME(S) TAKEN

_____

_____

_____

Describe what your child usually does during the last 30 minutes before bedtime:

_____

_____

_____

Does your child do any of the following in bed at night?

Read	YES	NO	DK
Watch TV	YES	NO	DK
Listen to the radio	YES	NO	DK
Other:_____			

EXCESSIVE DAYTIME SLEEPINESS

Does your child wake up feeling unrefreshed in the morning?	YES	NO	DK
Has your child had a problem with sleepiness during the day?	YES	NO	DK
Does your child appear sleepy during the day according to comments of a teacher or other supervisor?	YES	NO	DK
Is your child hard to wake up in the morning?	YES	NO	DK

SLEEP DISORDER BREATHING

While sleeping, does your child snore more than half the time?	YES	NO	DK
Have you ever seen your child stop breathing during the night?	YES	NO	DK

DURING SLEEP:

- Have you noticed your child's lips or fingernails turning bluish during sleep? YES NO DK
- Does your child sometimes adopt an unusual sleeping posture? If yes, please describe_____ YES NO DK
  _____
- Are you concerned about your child's breathing during sleep? YES NO DK
- Do you sometimes feel the need to arouse your child so that he/she will breathe? YES NO DK

UPON AWAKENING:

- Have you noticed irritability/bursts of anger upon awakening? YES NO DK

DAYTIME FEATURES:

- Is your child experiencing learning or memory difficulties? YES NO DK
- Is your child a habitual mouth breather in the daytime? YES NO DK
- Is hyperactivity a problem in the daytime? YES NO DK
  If yes, has your child been diagnosed with ADD or ADHD? YES NO DK

INSOMNIA

Does your child have difficulty falling asleep at night?	YES	NO	DK
Does your child wake up more than twice a night on average?	YES	NO	DK
Does your child have trouble falling back asleep if he/she wakes up at night?	YES	NO	DK

PERIODIC LIMB MOVEMENT

While your child is sleeping, have you seen repeated kicks or jerks of the legs at ***regular*** intervals (that is, about every 20 to 40 seconds? YES NO DK

Does your child complain of aching legs at bedtime? YES NO DK

Is your child a restless sleeper? YES NO DK

Does your child toss and turn in bed? YES NO DK

PARASOMNIAS

Does your child have nightmares? YES NO DK

*If yes, at what age did they begin?*_____ *How often do they occur?*_____

Does your child ever awaken suddenly with a scream and appear inconsolable? YES NO DK

If yes, how often? _____ *times per week*

Does your child sleep walk? YES NO DK

If yes, how often? _____ *times per week*

Does your child ever wet the bed? YES NO DK

If yes, how often? _____ *times per week*

SLEEP HABITS

Will your child fall asleep alone in bed? YES NO

In order to sleep, does your child need a special toy or object? YES NO

*If yes, describe:*_____

Does your child often need a bottle in order to go to sleep? YES NO

What type of bed does your child sleep in?

Crib Single Bed Double Bed Other_____

Does your child sleep alone? YES NO

*If no, who with?*_____

On which side of the body does your child usually sleep?

Left Side Right Side Back Face Down

What time is the bedroom light turned off?_____am/pm

Who turns off the light?_____

Is your child bothered by environmental noises at night? YES NO DK

If yes, please explain:_____

_____

As an infant, was your child "colicky"? YES NO DK

On average how long does it take your child to fall asleep? _____Hrs_____mins

What do you think prevents your child from falling asleep?

Fear Loneliness Not Sleepy Worries Other_____

Do you get annoyed/angry when your child cannot fall asleep? YES NO DK

How often does your child cry himself/herself to sleep? _____times per week

If yes, how long do you let your child cry? 10min 20min 30min as long as it takes

When unable to fall asleep, does your child get out of bed? YES NO DK NA
If yes, how long after getting in bed? _____Hrs_____mins
*If yes, once out of bed, what does your child do?*_____
_____

How long is your child up? _____Hrs_____mins

When your child returns to bed, how long does he/she take to fall back to sleep?
_____Hrs_____mins

If your child does not get out of bed, how long does he/she take to fall back to sleep?
_____Hrs_____mins

Once having fallen asleep, how long does your child typically sleep?
_____Hrs_____mins

Does your child awaken during the night? YES NO DK
If yes, how long will your child stay awake? _____Hrs_____mins

How often does your child awaken during the night? _____times

What time does your child finally awaken in the morning? _____am

What time does your child get out of bed in the morning? _____am

How does your child seem on awakening in the morning?_____
_____

Does your child nap during the day? YES NO DK
If yes, how often and how long? _____times a day _____hrs_____mins
What time of day does your child nap?_____

As the nighttime sleep period approaches, does your child become more alert? YES NO DK

Do you think a poor night's sleep affects your child's school performance
the next day? YES NO DK NA

Has a teacher commented on this? YES NO DK NA

Please state when your child was last able to sleep consistently without any problems.
Never _____years ago _____weeks ago _____months ago

At what time would you like your child to fall asleep now? _____

How long would you like your child to sleep? _____

What time would your like your child to awaken in the morning? _____

How long do you think children of your child's age should sleep? _____

Please add any other comments about your child's sleep problem that you think might be helpful:

Please list all people whom you have consulted about your child's sleep problem. Starting with the first, list the date, name, degree, specialty, investigations, treatment and outcome of all treatments (give medication details on next page).

DATE	NAME	DEGREE/SPECIALTY	INVESTIGATIONS /TREATMENT

Has your child had a tonsillectomy and/or adenoidectomy? YES NO DK
If yes, please give the date:_____
Has your child had nasal surgery to improve nasal airflow (e.g. a septoplasty)? YES NO DK
If yes, please give the date:_____
Has your child had a cleft palate repaired: YES NO DK
If yes, was a flap crated surgically? YES NO DK

Please list all medical illnesses that our child has been treated for in the past, or is currently being treated for.

DATE	ILLNESS	TREATMENT	OUTCOME

Please list any operations with dates below:

List any medications that have been prescribed in the past to help your child with his/her sleep problem. Give the name, dosage, time they were taken, how long they were taken for, any beneficial effects, why they were stopped. Start with the first one taken.

MED NAME	DOSE	TIME(s)	LENGTH	EFFECT	DATE STOPPED	WHY STOPPED

Have any of your child's parents, grandparents, brothers or sisters been diagnosed with:

Sleep Apnea?	Mom	Dad	Grandmother	Grandfather	Brother	Sister
Periodic Limb Movement Disorder?	Mom	Dad	Grandmother	Grandfather	Brother	Sister
Restless Leg Syndrome?	Mom	Dad	Grandmother	Grandfather	Brother	Sister

Please list any illness that may run in the family, such as diabetes, hypertension, heart disease, depression, emphysema, attention deficit hyperactivity (ADHD), etc.

CONDITION	FAMILY MEMBER	TREATMENT

Consent of Sleep Study:

I _____ understand that the Sleep Center at Valley View does conduct Audio
(Please Print Name of the Parent/Guardian)

and Video Recording for use in clinical evaluation and interpretation of the Sleep Study (Polysomnogram). Any recordings obtained will remain confidential and will be considered a protected portion of my medical record.

_____ _____
(Please Print Name of the Parent/Guardian) (Signature and Date of Polysomnographer):