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PHOEBE PUTNEY MEMORIAL HOSPITAL

Pediatric Sleep Questionnaire

Patient Name: _____ ☐Male ☐Female DOB: _____ Age: ____
Parent/Guardian: _____ Email: _____
Address: _____
City/State/Zip: _____
Primary Care Physician: _____ Referring Physician: _____
Neck size _____ (cm/inches) Height (inches): _____ Weight: _____ School Grade: _____

Describe your child's main problem(s) in your own words, including when and how this began and what treatment(s) your child has received for this in the past:

How long has this problem bothered your child?

☐ The last month
☐ The last 3 months
☐ Several months
☐ 1 to 2 years
☐ Longer than 2 years

How often does this problem occur?

☐ Every night
☐ Almost every night
☐ For periods of at least one week
☐ Irregularly
☐ Other

Is your child being treated for any medical conditions? If so please list below:

☐Hypertension (high blood pressure)	☐ Reflux
☐ Diabetes	☐ Other:
☐ Lung problems/asthma	☐
☐ ADD/ADHD	☐
☐ Seizures	☐
☐ Stomach or colon problems	☐

Does your child take any type of medication on a regular basis? ☐Yes ☐No **If YES, please list below**

Medication	Amount	How often	Reason

Has his/her tonsils been removed?	☐Yes ☐No **If so when?** _____
Has his/her adenoids been removed?	☐Yes ☐No **If so when?** _____
Has your child had a weight gain or loss in the last 6 months?	☐ Yes ☐ No **If so how much gained** _____ **or how much lost**_____**?**

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Using the scale below, estimate the severity of your child's problem(s):

☐ Mildly upsetting
☐ Moderately upsetting
☐ Very severe
☐ Extremely severe
☐ Totally incapacitating

How would you describe the sleep problem? (Check all that apply)

☐ Difficulty falling asleep
☐ Wake up during the night
☐ Wake up early in the morning
☐ Excessive daytime sleepiness
☐ Difficulty awakening

Do any other members of your family have sleep problems? ☐Yes ☐No **if yes, explain:**

Using the following scale, rate how often the following occurs:

1-Never (No) 2-Rarely 3-Sometimes 4-Frequently 5-Constantly (Yes)	**1**	**2**	**3**	**4**	**5**
Awaken from sleep short of breath					
Awaken with heartburn, belching or coughing					
Snore					
Snore loudly enough others complain					
Have trouble sleeping when he/she has a cold					
Suddenly wakes up gasping for breath during the night					
Have breathing problems at night					
Sweat at night					
Experience bedwetting while sleeping					
Fall asleep during the day					
Fall asleep while playing					
Fall asleep when laughing or crying					
Experience weakness when sad or happy					
Have trouble at school because of sleepiness					
Feel unable to move (paralyzed) when waking or falling asleep					
Experience dreamlike scenes upon waking up or falling asleep					
Feel afraid of going to sleep					
Have nightmares					
Remember his/her dreams					
Feel sad and depressed					
Have anxiety (worry about things)					
Notice parts of his/her body jerk					
Kick during the night					
Have crawling and aching feeling in his/her legs					
Have any type of leg pain during the night					
Have morning jaw pain					
Grind teeth during sleep					
Bothered by pain during the day					
Awakened by pain during the night					
Wake up feeling stiff in the mornings					
Wake up with sore or achy muscles					
Wake up with pain in neck, spine or joints					

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Is your child's present school situation satisfactory? ☐Yes ☐No (if no, explain):
How many hours of sleep does your child get per night? _____ hours
What is your child's typical bedtime? _____Weekdays _____Weekends
How long does it take for your child to fall asleep? _____minutes/hours
Typical number of awakenings per night? _____
If he/she awakens, how long does he/she average staying awake? _____minutes/hours
What does your child usually do when he/she awakens during the night?
When do these awakenings typically happen? ☐ Soon after falling asleep ☐ Middle of the night ☐ Early morning
Typical wake up time each morning? _____a.m./p.m. Weekdays _____a.m./p.m. Weekends
On average, how long does your child stay in bed after waking up in the morning? _____minutes/hours
Mark all that apply to your child: ☐ Usually sleeps with someone else in his/her bed. ☐ Usually sleeps with someone else in his/her room.
Mark all that often disturb your child's sleep: ☐ Heat ☐ Cold ☐ Light ☐ Noise ☐ Bed partner ☐ Not being in his/her usual bed ☐ Other: _____
Are your child's sleep habits on the weekends different from the rest of the week? ☐ Yes (if yes describe) ☐ No
With whom is your child now living? (Siblings, parents, etc., please list ages)
Does your child drink coffee, tea or soft drinks within two hours of going to bed? ☐Yes ☐No

List below in the appropriate space your child's consumption per day of the following items: (list names where applicable)	Amount Consumed:
Coffee	_____oz.
Soft Drinks	_____oz.
Chocolate	_____oz.
Nicotine	_____
Alcohol	_____oz.
Over the counter drugs	_____
Other drugs not listed above	_____

Does your child take naps during the afternoon or evening? ☐Yes ☐No
How does your child feel after an average night of sleep? ☐ Usually drowsy and/or tired for up to 1 hour. ☐ Usually drowsy and/or tired for up to 2 hours. ☐ Usually drowsy and/or tired for 3 hours or longer. ☐ Good most of the time. ☐ Consistently good.
Does your child feel better during the ☐ morning ☐ afternoon, or ☐ evening?

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