Date: _____

UB|MD PEDIATRICS
SLEEP CENTER

AASM ACCREDITED Facility Member

PEDIATRIC SLEEP QUESTIONNAIRE for NEW PATIENTS

Please answer the following questions by filling in the blanks or checking the appropriate responses. You may omit questions that you do not feel like they apply to your child or that you do not wish to answer.

Child's Name: _____ Sex: M_____ F_____

Birthdate: _____ Age: _____ Height: _____ Weight: _____

Address: _____

_____

Primary phone: _____ Alternate phone: _____

Email address: _____

REFERRING PHYSICIAN

Name: _____

List here any other provider that you would like us send your child's notes to:

Name: _____

SLEEP HISTORY

Please describe the reason you sought or are seeking this evaluation for your child:

_____

Has your child had a previous sleep study? ☐ Yes ☐ No

If yes, where was the study done? _____ Date of the study: _____

Has your child had an ENT evaluation? ☐ Yes ☐ No. Name of ENT: _____

Has your child ever had an adenoidectomy/tonsillectomy? ☐ Yes ☐ No; Date: _____

What time does your child get into bed on school days? _____ Weekends? _____

What time does your child wake up on weekdays? _____ Weekends? _____

How long does your child read, watch TV, etc after getting into bed? ____minutes

How long does it usually take your child to fall asleep? _____minutes

On an average night, how many times does your child wake up before morning?

☐ 0 ☐ 1-2 times ☐ 3-4 times ☐ More than 4 times

If your child does wake up during the night, how long does it take for him/her to go back to sleep?

☐ Less than 10 minutes ☐ 10-30 minutes ☐ 30-60 minutes ☐ Over 1 hour

How many days a week does your child wake up early and can't go back to sleep?

☐ None ☐ 1-2 days/week ☐ 3-4 days/week ☐ Over 5 days per week

How many nights a week does your child sleep in the same room or bed as you or another person?

☐ None ☐ 1-2 days/week ☐ 3-4 days/week ☐ Over 5 days per week

How often does your child take naps or fall asleep during the day?

☐ None ☐ 1-2 days/week ☐ 3-4 days/week ☐ Over 5 days per week

If your child naps, how long do the naps last?

☐ 10-30 minutes ☐ 30-60 minutes ☐ 1-2 hours ☐ Over 2 hours

	No	Yes
Does your child **sleep with their mouth open**?		
Does your child **drool** at night?		
Does your child **snore?**		
Does he/she **grind their teeth** while asleep?		
Does he/she **move or kick their legs** a lot while asleep?		
Does he/she **sweat** in their sleep?		
Is he/she a **restless sleeper**?		
Any **bed-wetting** (if potty trained)?		
Any **body rocking/head banging**?		
Wake up with **morning headaches** or **bellyaches**?		
Wake up **thirsty** or with a **dry mouth** or **sore throat**?		
Are they hard to get moving/wake up in the morning?		
Do they **look tired** or **act cranky** throughout the day?		

Has your child been diagnosed with any of these medical conditions?

	No	Yes	Any treatment or surgery?
Asthma			
Recurrent ear infections or colds			
Chronic nasal congestion or allergies			
Learning problems at school			
Behavioral problems at school			
Mood swings			
Recurrent headaches			
ADHD or inattention, problems focusing			

Speech delay			
Delays in motor development (fine or gross)			
Too much or too little weight gain			
Stomach acid reflux (GER)			
Neurologic or Muscular disorder			
Genetic disease			
Craniofacial disorder			

List any other medical problems here: _____

_____

MEDICATIONS

Please list any prescription or non-prescription medications (including things to help them sleep) your child is taking:

Medication Name	Amount	How often?

Epworth Sleepiness Scale

Think of your child's usual way of life in recent times even if you have not done some of these things recently.

How likely is it for your child to <u>doze off</u> or <u>fall asleep</u> in the following situations?	**Never** fall asleep	**Slight** chance of sleep	**Moderate** chance of sleep	**High** chance of sleep
1. Sitting and reading (or being read to)	0	1	2	3
2. Watching television (or a computer)	0	1	2	3
3. Sitting inactive in a public place (i.e. movie theater, waiting room)	0	1	2	3
4. Riding in a car for 1 hour or more	0	1	2	3
5. Lying down to rest outside of nap time	0	1	2	3
6. Sitting and talking to someone	0	1	2	3
7. Sitting quietly after a meal	0	1	2	3
8. Doing school work or taking a test	0	1	2	3

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OSA-18 Quality of Life Survey

For each question below, check the box that best described how often each symptom or problem has occurred in your child in the LAST MONTH.

In the **LAST MONTH**, how often has your child had	**Never**	**Hardy at all**	**A little of the time**	**Some of the time**	**A good bit of the time**	**Most of the time**	**All of the time**
…loud snoring?							
…breath-holding or pauses in breathing at night?							
…choking or gasping sounds while asleep?							
…restlessness or frequent awakening from sleep?							
…mouth breathing because of nasal obstruction?							
…frequent colds or upper respiratory infections?							
…nasal discharge or runny nose?							
…difficulty in swallowing foods?							
…mood swings or temper tantrums?							
…aggressive or hyperactive behaviors?							
…discipline problems?							
…excessive daytime sleepiness or drowsiness?							
…poor attention span or concentration?							
…difficulty getting out of bed in the morning?							
CAREGIVERS: In the LAST MONTH, how often have these problems in your child….							
…caused YOU to worry about your child's general health?							
…caused concern that your child is not getting enough air?							
…interfered with YOUR ability to perform daily activities?							
…made YOU frustrated?							