DATE COMPLETED: ___/___/___

PEDIATRIC SLEEP CLINIC QUESTIONNAIRE
BACKGROUND INFORMATION (4-12 years)

1. Name of patient _____

2. Date of birth: _____/_____/_____

3. Gender of child: ☐ Male ☐ Female

4. Name of person completing questionnaire: _____

   a. Relationship to Child:

      ☐ Biological Parent ☐ Adoptive Parent ☐ Foster Parent ☐ Step Parent

      ☐ Other _____

5. What best describes your child's ethnic background? ☐ Hispanic or Latino ☐ Not Hispanic or Latino

6. What best describes your child's racial background?

   ☐ White/Caucasian ☐ Asian

   ☐ Black/African American ☐ American Indian or Alaska Native

   ☐ Native Hawaiian or other Pacific Islander

   ☐ Multiracial (Please specify) _____

   ☐ Other (Please specify):_____

7. Referred by: _____

   a. Address: _____

      _____

8. Is your pediatrician different than the referring doctor? ☐ Yes ☐ No

   a. If yes, please provide information for your pediatrician

      Name: _____

      Address: _____

      _____

9. A copy of the sleep clinic evaluation report will be sent to you, your pediatrician, and any referring physician (if different than pediatrician). Please indicate anyone else who should receive a copy:

   Name: _____

   Address: _____

   _____

10. What are your major concerns about your child's sleep? _____

_____

_____

11. What do you think is causing your child's sleep problem? _____

_____

12. How long has your child had difficulty with sleep?

☐ 1 month or less ☐ 2–6 months ☐ 6–12 months ☐ 1–5 years ☐ More than 5 years

13. Has your child ever been diagnosed with a sleep disorder? ☐ Yes ☐ No

a. If yes, please specify what, when, and what, if any, treatment was given): _____

_____

_____

14. Why are you seeking an evaluation of your child's sleep problems at this time? _____

_____

15. What are your goals for this evaluation?

_____

_____

FAMILY INFORMATION

16. Please list all members of the household in which your child sleeps most of the time:

Name	Age	Relationship to Child
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

17. Does your child regularly sleep in another household? ☐ Yes ☐ No

If yes, please specify where: _____

If yes, on average, how many nights per month? _____

18. Please list all members of the other household in which your child sleeps:

Name	Age	Relationship to Child
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

For questions 19–22, "Parent 1" refers to the first caregiver in the household in which your child sleeps most of the time.

19. Relationship of Parent 1 to child:

    ☐ Mother ☐ Father ☐ Other _____

20. Parent 1's marital status:

    ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Single ☐ Living with partner

    a. If divorced, child custody shared with: _____

21. Parent 1's highest level of education: _____

22. Parent 1's occupation: _____

    a. Does Parent 1 work outside of home? ☐ Yes ☐ No

    b. If yes, mark any labels that best describe his/her work:

    ☐ Day Shift ☐ Evening Shift ☐ Overnight Shift ☐ Full Time ☐ Part Time

For questions 23–27, "Parent 2" refers to the first caregiver in the household in which your child sleeps most of the time.

23. Is there a second parent in the household in which your child sleeps most of the time?

    ☐ Yes ☐ No (if no, continue to question 28)

24. Relationship of Parent 2 to child:

    ☐ Mother ☐ Father ☐ Other _____

25. Parent 2's marital status:

    ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Single ☐ Living with partner

    a. If divorced, child custody shared with: _____

26. Parent 2's highest level of education: _____

27. Parent 2's occupation: _____

    a. Does Parent 2 work outside of home? ☐ Yes ☐ No

    b. If yes, mark any labels that best describe his/her work:

    ☐ Day Shift ☐ Evening Shift ☐ Overnight Shift ☐ Full Time ☐ Part Time

28. Please list family members (parents, grandparents, siblings) with a history of any SLEEP PROBLEMS (including: loud snoring/obstructive sleep apnea, excessive sleepiness/ narcolepsy, restless legs/periodic leg movement, insomnia, other sleep problems).

Family Member	Type of Sleep Problem
_____	_____
_____	_____
_____	_____
_____	_____

29. Please list any family members with a history of mental health problems (such as depression, ADHD, anxiety, alcoholism/substance abuse).

Family Member	Type of Mental Health Problem
_____	_____
_____	_____
_____	_____
_____	_____

HEALTH HISTORY

BIRTH HISTORY

30. Did you or your doctor note any problems with pregnancy (e.g., drug/alcohol abuse, cigarette use, high blood pressure)? _____

31. Child was born at _____weeks gestation.

32. Please list any complications in the newborn period: _____

_____

33. Was your child sent home on an apnea monitor? ☐ Yes ☐ No

MEDICAL HISTORY

34. Does your child have a history of health problems? ☐ Yes ☐ No

If so, please list: _____

_____

35. Has your child ever had (check all that apply):

☐ Oxygen therapy ☐ CPAP/BiPAP ☐ Caffeine/theophylline ☐ Tracheostomy

36. Does your child currently have any health problems? ☐ Yes ☐ No

If so, please list: _____

_____

37. Does your child currently have (check all that apply):

☐ Oxygen therapy ☐ CPAP/BiPAP ☐ Caffeine/theophylline ☐ Tracheostomy

38. Has your child ever been hospitalized overnight? ☐ Yes ☐ No

If yes, please list approximate dates and reason for hospitalization: _____

_____

39. Have your child's tonsils and/or adenoids been removed? ☐ Yes ☐ No

a. Tonsils Date(s): _____

b. Adenoids Date(s): _____

c. Both Date(s): _____

d. For what reason: _____

e. Describe briefly any changes you noticed in your child's sleep or waking behavior after removal of tonsils and/or adenoids: _____

_____

_____

40. Has your child ever had an operation (other than removal of tonsils and adenoids)?
☐ Yes ☐ No

If yes, please list type/date(s): _____

41. Has your child ever had a head injury/concussion requiring medical evaluation?
☐ Yes ☐ No

If yes, please list date(s) and briefly describe: _____

42. Has your child ever had a serious injury (other than head injury)? ☐ Yes ☐ No

If yes, please list type/date(s): _____

43. Please indicate if your child has had or currently has any of the following:
(Check all that apply)

	Currently	At any time in the past
A. Broken bones (nose/face)	☐	☐
B. Nasal congestion/difficulty breathing through nose	☐	☐
C. Frequent strep throat/tonsillitis	☐	☐
D. Frequent ear infections	☐	☐
E. Frequent colds/respiratory infections like bronchitis	☐	☐
F. Frequent sinus infections	☐	☐
G. Allergies: If yes, to what: _____ _____	☐	☐
	Currently	At any time in the past
H. Asthma	☐	☐
I. Eczema/Skin allergies	☐	☐
J. Other respiratory problems: _____ _____	☐	☐
K. Acid (Gastroesophageal) reflux	☐	☐
L. Poor or slow growth	☐	☐
M. Overweight/Obesity	☐	☐

N. Seizures/Convulsions	☐	☐
O. Frequent and/or severe headaches	☐	☐
P. Frequent heartburn	☐	☐
Q. Thyroid problems	☐	☐

44. List any prescription or over-the-counter medications your child has taken in the last month:

    Type _____ Reason for medication: _____

    Type _____ Reason for medication: _____

    Type _____ Reason for medication: _____

45. Do you have additional comments about your child's health?:

    _____

    _____

    _____

    _____

SLEEP HISTORY

Sleep Habits: For the next set of questions, think about your child's sleep during the **past month** (if the past month has been unusual, think about a typical month)

Weeknight/School Night Schedule:

46. What time does your child usually **go to bed** on weeknights? _____ p.m./a.m.

47. How long does it usually take your child to **fall asleep** on weeknights? _____ hours _____ minutes

48. How many times does your child usually wake up at night? _____ How long are the wakings? _____

49. How often does your child have difficulty returning to sleep after a night waking?

    Please check **one:** ☐ Always ☐ Frequently ☐ Sometimes ☐ Occasionally ☐ Rarely/never

50. What time does your child **wake up** on weekdays? _____ p.m./a.m.

51. On average, **how long does your child sleep** on weeknights? _____ hours _____ minutes

52. On weekdays, does your child usually:

    a. Nap? ☐ Yes ☐ No

       If yes, how many days/week: _____

       Number of naps: _____

       Average length of naps: _____

    b. Wake up on his/her own? ☐ Yes ☐ No

    c. Need to be awakened by an alarm clock or caregiver? ☐ Yes ☐ No

Weekend/ Vacation Schedule:

53. What time does your child usually **go to bed** on weekends? _____ p.m./a.m.

54. How long does it usually take your child to **fall asleep** on weekends? _____ hours _____ minutes

55. How many times does your child usually wake up at night? _____ How long are the wakings? _____

56. How often does your child have difficulty returning to sleep after a night waking?

    Please check **one**: ☐ Always ☐ Frequently ☐ Sometimes ☐ Occasionally ☐ Rarely/never

57. What time does your child **wake up** on weekends? _____ p.m./a.m.

58. On average, **how long does your child sleep** on weekends? _____ hours _____ minutes

59. On weekdays, does your child usually:

    a. Nap? ☐ Yes ☐ No

    If yes, how many days: _____

    Number of naps: _____

    Average length of naps: _____

    b. Wake up on his/her own? ☐ Yes ☐ No

    c. Need to be awakened by an alarm clock or caregiver? ☐ Yes ☐ No

60. How much sleep do you think your child needs? _____

61. If your child sets his/her own schedule, which would s/he prefer (think about his/her sleep patterns during the summer/on weekends). Please check **one:**

    ☐ Go to bed early and get up early ☐ Go to bed late and get up late ☐ No preference

62. Has your child ever taken over-the-counter or prescription medications at bed time to help her/him calm down and/or fall asleep? ☐ Yes ☐ No

    If yes, please list the medication(s) and dose:_____

63. Which of the following items does your child have in her/his bedroom? (Please check all that apply)

    ☐ TV ☐ DVD/VCR ☐ Computer ☐ Internet access ☐ Video game system

    ☐ Telephone/cell phone

64. In the past (or typical) month, how often has your child:

	Never/rarely	1–2x/week	3–5x/week	Every day
Had behavior problems in the evening?	☐	☐	☐	☐
Had a regular bedtime routine?	☐	☐	☐	☐
Resisted going to bed?	☐	☐	☐	☐
Had difficulty falling asleep at his/her regular bedtime?	☐	☐	☐	☐
Fallen asleep in your bed?	☐	☐	☐	☐
Called you back into the bedroom after lights out?	☐	☐	☐	☐
Come out of the bedroom after lights out?	☐	☐	☐	☐
Come into your room during the night?	☐	☐	☐	☐
Kicked his/her legs during sleep?	☐	☐	☐	☐
Drank caffeinated beverages (like cola, iced tea)?	☐	☐	☐	☐

65. Do you have additional comments about your child's sleep?

_____

_____

_____

_____