

PEDIATRIC SLEEP QUESTIONNAIRE

Child's Name: _____ Date of Birth: _____ Gender: Male Female

Name of person completing this questionnaire: _____

Relationship to child: _____ Date: _____

PREGNANCY/DELIVERY

Was the mother's pregnancy healthy? Yes No (If No Please Explain)

Length of pregnancy? _____ (Weeks)

Mode of delivery? Vaginal C-Section Vacuum Assist

Problems with your baby after delivery? Yes No (If Yes Please Explain)

Please tell about your child's current sleep-related symptoms and your concerns.

Reason for Sleep Study Referral: (check all that apply)

- Measure breathing problems during sleep
- Follow-up sleep study after surgery or other treatment
- Evaluate need for extra oxygen at night
- Evaluate need for CPAP or BiPAP
- Evaluate nighttime choking or gasping
- Evaluate the child's unusual movements, behaviors, or waking's at night
- Evaluate excess daytime sleepiness or napping
- Other: _____

Please write in your own words what are your child's main sleep trouble(s) or current symptoms, what things you've tried to do to help, and what things might be causing these problems?

Surgery to remove tonsils? Yes No If Yes, date: _____ / _____ (mm/yy)
 Surgery to remove adenoids? Yes No If Yes, date: _____ / _____ (mm/yy)

CHILD'S SLEEP/WAKE SCHEDULE

Is your child's sleep routine regular? Yes No

	School or Weekdays	Non-School or Weekends
Usual Bedtime		
Time When Child Really Falls Asleep		
Usual Wake Time		

Napping

None or Number of naps: _____ Hours napping: _____

Current Medications (list all, prescription and non-prescription)

CURRENT SLEEP ENVIRONMENT AND BEHAVIOR

What position does your child usually sleep in?

- His/her back Back and side or stomach
 His/her side All positions
 His/her stomach Sitting up or propped up with pillows
 Not sure

Where does your child fall sleep?

- Own bed Someone else's bed With whom? _____
 Own room Someone else's bed With whom? _____

How does your child fall asleep?

- Parent is with child when falling asleep Sibling is with child when falling asleep

Any other habits when falling asleep? Yes No (If Yes Please Explain)

Where does your child sleep most of the night? Describe below:

SLEEP AND BREATHING

If snoring or noisy breathing is present, how noisy has your child usually been in the past month?

- Does not apply Louder than talking
 Only slightly louder than heavy breathing Extremely loud/can be heard through a closed door
 About as loud as mumbling or talking Not sure

SLEEP SYMPTOMS OR PROBLEMS

If the symptom or problem does not apply to your child, then check "Not Applicable"

	Usually (5-7/wk)	Sometimes (2-4/wk)	Rarely (0-1/wk)	Not Applicable
Child has trouble falling asleep at night	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Child awakes once during the night	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Child wakes more than once during the night	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Child sleeps too little	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Child sleeps too much	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Child wets the bed at night	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Child makes noises/talks during sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Child is restless and moves a lot during sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Child sleepwalks during the night	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Child awakens during night screaming, sweating and inconsolable	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Child grinds teeth during sleep (dentist may have told you this)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Child moves to someone else's bed during the night (parent, sibling, etc)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Child reports body pains during sleep. If so, where?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Child has noisy breathing or snoring	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Child seems to stop breathing during sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Child snorts and/or gasps during sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Child is very sweaty during sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Child has frequent leg jerks or kicks during sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Child complains of weird feelings or "growing pains" in his/her legs at night	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Child has vivid or scary dreams when falling asleep or upon waking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Child says he/she can't move just as he/she is falling asleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Child awakens alarmed by a frightening dream	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

MORNING WAKING

	Usually (5-7/wk)	Sometimes (2-4/wk)	Rarely (0-1/wk)	Not Applicable
Child has difficulty getting out of bed in the morning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Child takes a long time to become alert in the morning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Child says he/she can't move when first waking in the morning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Child is tardy for school or is missing school because of sleepiness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

DAYTIME SYMPTOMS

	Usually (5-7/wk)	Sometimes (2-4/wk)	Rarely (0-1/wk)	Not Applicable	Problem	
					Yes	No
Child naps during the day	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Child suddenly falls asleep in the middle of active behavior	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Child acts sleepy or seems overtired a lot	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Child falls down, loses muscle tone, gets weak in the knees or jaw, when laughing or with strong emotions.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Child reports dreams, sometimes scary, during daytime	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

ACTIVITIES

During the past month, in which of the following activities has your child appeared very sleepy or fallen asleep?

	Very sleepy	Falls Asleep	No Problem	Not Applicable	Problem	
					Yes	No
Playing alone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Playing with others	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Watching TV	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Playing a video game	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Riding in car	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eating meals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Getting dressed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Going to the bathroom	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
In school (if applicable)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
After school (if applicable)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

MEDICAL HISTORY

Have you ever been told by a teacher, school official, doctor, nurse or other health professional that your child has any of the following conditions?

	No	Yes	Not sure
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chronic lung or breathing trouble (NOT ASTHMA)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tracheostomy (surgical hole in the neck)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Trouble breathing through the nose	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chronic allergies or sinus problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Frequent ear infections	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Frequent throat infections	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Craniofacial problems (e.g. – small face or jaw, Pierre-Robin)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cerebral palsy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy (seizure disorder)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Spina bifida (problem with spinal cord and lower brain)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Muscle weakness (for example, muscular dystrophy)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Migraine headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hearing impairment or deafness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vision impairment or blindness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chronic arthritis or rheumatic disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chronic orthopedic bone or joint problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Skeletal problems (dwarfism, achondroplasia)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Obesity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Genetic problems (for example, Down’s syndrome)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart problem (for example, hole in the heart, murmur)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Swallowing problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gastro-esophageal reflux	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Poor weight gain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sickle cell disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hormone problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eczema (skin allergies)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Allergies to medicines or foods	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Learning problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ADHD (Attention deficit or hyperactivity disorder)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Developmental delay or Intellectual Disability	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Autism Spectrum Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anxiety problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Behavioral or emotional problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Obsessive compulsive disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

MEDICAL HISTORY Continued

	No	Yes	Not sure
Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Suicide attempts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Drug abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Admissions to hospital for psychiatric (mental health) problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

SCHOOL HISTORY - (If your child is too young for school, skip this page.)

School Placement: Current grade level: _____ (If summertime, then enter the grade level for upcoming fall.)

- Regular classroom
 Severe behavior problem classroom
 Home schooling
 Multiple handicapped classroom
 Learning disabilities class/resource room
 Other: (please describe)

	No	Yes	Not sure
Current concerns about your child's school performance?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Current concerns about your child's behavior at school?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Has your child ever repeated a grade? If YES, what grade (s) _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Has your child ever been expelled or suspended?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Has your child's teacher discussed with you any concerns about academic performance, behavior, or social relationships?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If your child is in school, how are his/her grades? (Mark box below)

Child's grades	Excellent	Good	Average	Poor	Failing	Not sure
Current year	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Last year	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Current academic performance is:

- Same as last year
 Worse than last year
 Better than last year

Missed School Days:	< 5 days	5-10 days	10-20 day	20-30 days	30+ days
Current year	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Last year	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

FAMILY HISTORY

Has either parent been told by a doctor or other health professional that the parent had any of the following:

	No	Yes	Not sure
Sleep apnea diagnosed in a sleep laboratory or treated with CPAP (continuous positive airway pressure)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Narcolepsy (excessive daytime sleepiness, dream sleep attacks)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
"Restless legs syndrome" (uncomfortable, crawling feelings in the legs most bothersome at night) or	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
"Periodic limb movement syndrome" (frequent, leg kicks or jerks or kicks during sleep)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Has your child's teacher discussed with you any concerns about academic performance, behavior, or social relationships?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

EPWORTH SLEEPINESS SCALE

This section is only to be completed for children ages 6 and up. If child is under 6 years old, please leave section blank.

This questionnaire was developed to determine the level of daytime sleepiness in individuals. It has become one of the most frequently used methods for determining a person's average level of daytime sleepiness.

How likely is your child to doze off or fall asleep in the following situations, in contrast to feeling just tired? This refers to your child's usual way of life in recent times. Even if your child has not done some of these things recently, think about how these things would have affected them. Use the following scale to choose the most appropriate number for each situation.

Please mark "✓" as appropriate:	Would never doze	Slight chance of dozing	Moderate chance of dozing	High chance of dozing
	0	1	2	3
1. Sitting and reading	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Watching TV	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Sitting, in a public place (e.g. in a class room or movie theater)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. As a passenger in a car for an hour without a break	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Lying down to rest in the afternoon	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Sitting down and talking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Sitting quietly after lunch	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. While playing a video game	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
TOTAL SCORE:				

Is there anything else you would like me to know about your child?

A large, empty rectangular box with a thin blue border, intended for the user to provide additional information about their child.