OCEAN MEDICINE

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AASM ACCREDITED Facility Member™

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

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
- ☐ Only slightly louder than heavy breathing
- ☐ About as loud as mumbling or talking
- ☐ Louder than talking
- ☐ Extremely loud/can be heard through a closed door
- ☐ 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	☐	☐	☐	☐
Child awakes **once** during the night	☐	☐	☐	☐
Child wakes **more than once** during the night	☐	☐	☐	☐
Child sleeps too little	☐	☐	☐	☐
Child sleeps too much	☐	☐	☐	☐
Child wets the bed at night	☐	☐	☐	☐
Child makes noises/talks during sleep	☐	☐	☐	☐
Child is restless and moves a lot during sleep	☐	☐	☐	☐
Child sleepwalks during the night	☐	☐	☐	☐
Child awakens during night screaming, sweating and inconsolable	☐	☐	☐	☐
Child grinds teeth during sleep (dentist may have told you this)	☐	☐	☐	☐
Child moves to someone else's bed during the night (parent, sibling, etc)	☐	☐	☐	☐
Child reports body pains during sleep. If so, where?	☐	☐	☐	☐
Child has noisy breathing or snoring	☐	☐	☐	☐
Child seems to stop breathing during sleep	☐	☐	☐	☐
Child snorts and/or gasps during sleep	☐	☐	☐	☐
Child is very sweaty during sleep	☐	☐	☐	☐
Child has frequent leg jerks or kicks during sleep	☐	☐	☐	☐
Child complains of weird feelings or "growing pains" in his/her legs at night	☐	☐	☐	☐
Child has vivid or scary dreams when falling asleep or upon waking	☐	☐	☐	☐
Child says he/she can't move just as he/she is falling asleep	☐	☐	☐	☐
Child awakens alarmed by a frightening dream	☐	☐	☐	☐

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	☐	☐	☐	☐
Child takes a long time to become alert in the morning	☐	☐	☐	☐
Child says he/she can't move when first waking in the morning	☐	☐	☐	☐
Child is tardy for school or is missing school because of sleepiness	☐	☐	☐	☐

DAYTIME SYMPTOMS

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

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	☐	☐	☐	☐	☐	☐
Playing with others	☐	☐	☐	☐	☐	☐
Watching TV	☐	☐	☐	☐	☐	☐
Playing a video game	☐	☐	☐	☐	☐	☐
Riding in car	☐	☐	☐	☐	☐	☐
Eating meals	☐	☐	☐	☐	☐	☐
Getting dressed	☐	☐	☐	☐	☐	☐
Going to the bathroom	☐	☐	☐	☐	☐	☐
In school (if applicable)	☐	☐	☐	☐	☐	☐
After school (if applicable)	☐	☐	☐	☐	☐	☐

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	☐	☐	☐
Chronic lung or breathing trouble (NOT ASTHMA)	☐	☐	☐
Tracheostomy (surgical hole in the neck)	☐	☐	☐
Trouble breathing through the nose	☐	☐	☐
Chronic allergies or sinus problems	☐	☐	☐
Frequent ear infections	☐	☐	☐
Frequent throat infections	☐	☐	☐
Craniofacial problems (e.g. – small face or jaw, Pierre-Robin)	☐	☐	☐
Cerebral palsy	☐	☐	☐
Epilepsy (seizure disorder)	☐	☐	☐
Spina bifida (problem with spinal cord and lower brain)	☐	☐	☐
Muscle weakness (for example, muscular dystrophy)	☐	☐	☐
Migraine headaches	☐	☐	☐
Hearing impairment or deafness	☐	☐	☐
Vision impairment or blindness	☐	☐	☐
Chronic arthritis or rheumatic disease	☐	☐	☐
Chronic orthopedic bone or joint problems	☐	☐	☐
Skeletal problems (dwarfism, achondroplasia)	☐	☐	☐
Obesity	☐	☐	☐
Diabetes	☐	☐	☐
Genetic problems (for example, Down's syndrome)	☐	☐	☐
Heart problem (for example, hole in the heart, murmur)	☐	☐	☐
Swallowing problems	☐	☐	☐
Gastro-esophageal reflux	☐	☐	☐
Poor weight gain	☐	☐	☐
Sickle cell disease	☐	☐	☐
Hormone problems	☐	☐	☐
Eczema (skin allergies)	☐	☐	☐
Allergies to medicines or foods	☐	☐	☐
Pain	☐	☐	☐
Learning problems	☐	☐	☐
ADHD (Attention deficit or hyperactivity disorder)	☐	☐	☐
Developmental delay or Intellectual Disability	☐	☐	☐
Autism Spectrum Disorder	☐	☐	☐
Anxiety problems	☐	☐	☐
Behavioral or emotional problems	☐	☐	☐
Obsessive compulsive disorder	☐	☐	☐

MEDICAL HISTORY Continued

	No	Yes	Not sure
Depression	☐	☐	☐
Suicide attempts	☐	☐	☐
Drug abuse	☐	☐	☐
Admissions to hospital for psychiatric (mental health) problems	☐	☐	☐

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?	☐	☐	☐
Current concerns about your child's behavior at school?	☐	☐	☐
Has your child ever repeated a grade? If YES, what grade (s) _____	☐	☐	☐
Has your child ever been expelled or suspended?	☐	☐	☐
Has your child's teacher discussed with you any concerns about academic performance, behavior, or social relationships?	☐	☐	☐

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	☐	☐	☐	☐	☐	☐
Last year	☐	☐	☐	☐	☐	☐

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	☐	☐	☐	☐	☐
Last year	☐	☐	☐	☐	☐

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)	☐	☐	☐
Narcolepsy (excessive daytime sleepiness, dream sleep attacks)	☐	☐	☐
"**Restless legs syndrome**" (uncomfortable, crawling feelings in the legs most bothersome at night) or	☐	☐	☐
"**Periodic limb movement syndrome**" (frequent, leg kicks or jerks or kicks during sleep)	☐	☐	☐
Has your child's teacher discussed with you any concerns about academic performance, behavior, or social relationships?	☐	☐	☐

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	☐	☐	☐	☐
2. Watching TV	☐	☐	☐	☐
3. Sitting, in a public place (e.g. in a class room or movie theater)	☐	☐	☐	☐
4. As a passenger in a car for an hour without a break	☐	☐	☐	☐
5. Lying down to rest in the afternoon	☐	☐	☐	☐
6. Sitting down and talking	☐	☐	☐	☐
7. Sitting quietly after lunch	☐	☐	☐	☐
8. While playing a video game	☐	☐	☐	☐
TOTAL SCORE:				**0**

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