

Athens Center for Sleep Disorders

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Pediatric Sleep Evaluation Questionnaire

Child's Information	
Child's Name:	Child's Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female
Child's Birth date:	Child's Age:
Child's Social Security No.:	Today's Date:
Child's Primary Doctor:	Child's Referring Doctor:

Child's Problem or Area of Concern
What are your major concerns about your child's sleep? _____
What things have you done to help your child's problem?

Referral
Who asked that your child be seen by a sleep specialist?
<input type="checkbox"/> Pediatrician / Family Physician
<input type="checkbox"/> Child's parent or Guardian
<input type="checkbox"/> Surgical Specialist (e.g., ENT)
<input type="checkbox"/> Pediatric Specialist (e.g., allergist, neurologist, pulmonologist)
<input type="checkbox"/> Mental Health Worker (e.g., psychiatrist, psychologist, social worker)
<input type="checkbox"/> School teacher, nurse, counselor
<input type="checkbox"/> Child himself / herself
<input type="checkbox"/> Other: _____

Sleep History

Weekday Sleep Schedule

Write in the amount of time the child sleeps during a 24 hour period on weekdays. (add daytime and nighttime sleep)

_____ hours _____ minutes

Child's usual bedtime on weekday nights:

_____ :

Child's usual wake time on weekday mornings:

_____ :

Weekend / Vacation Sleep Schedule

Write in the amount of time the child sleeps during a 24 hour period on weekends or vacation days. (add daytime and nighttime sleep)

_____ hours _____ minutes

Child's usual bedtime on weekday nights:

_____ :

Child's usual wake time on weekday mornings:

_____ :

Nap Schedule

Number of days each week the child takes a nap:

1 2 3 4 5 6 7

If the child naps write in the usual nap time(s):

Nap #1 _____ : _____ a.m. p.m. To _____ : _____ a.m. p.m.

Nap #2 _____ : _____ a.m. p.m. To _____ : _____ a.m. p.m.

General Sleep

Does the child have a regular bedtime routine? Yes No

Does the child have his / her own bed? Yes No

Does the child have his / her own bedroom? Yes No

Is a parent / guardian present when the child falls asleep? Yes No

Does the child listen / watch radio / TV in bed? Yes No

Child usually falls asleep in:

- own room in own bed (alone)
- parent's room in own bed
- parent's room in parent's bed
- sibling's room in own bed
- sibling's room in sibling's bed

Child sleep most of the night in:

- own room in own bed (alone)
- parent's room in own bed
- parent's room in parent's bed
- sibling's room in own bed
- sibling's room in sibling's bed

Child usually wakes in the morning in:

- own room in own bed (alone)
- parent's room in own bed
- parent's room in parent's bed
- sibling's room in own bed
- sibling's room in sibling's bed

Child is usually put in bed by: Mother Father Both parents Sibling Self Others

Write the amount of time the child spends in his / her bedroom before going to sleep: _____ Minutes

Child resists going to bed? Yes No IF yes, do you think this is a problem? Yes No

Child has difficulty falling asleep? Yes No IF yes, do you think this is a problem? Yes No

Child awakens during the night? Yes No IF yes, do you think this is a problem? Yes No

After a night time awakening, child has difficulty going back asleep? Yes No IF yes, do you think this is a problem? Yes No

Child is difficult to wake in the morning? Yes No IF yes, do you think this is a problem? Yes No

Child is a poor sleeper? Yes No IF yes, do you think this is a problem? Yes No

Current Sleep Symptoms

- (A) Never (does not happen)
 (B) Not Often (less than 1 night / day a week)
 (C) Sometimes (1 to 2 nights / days a week)
 (D) Often (3 to 5 nights / days a week)
 (E) Always (6 to 7 nights / days a week)
 (F) Do Not Know

1	Stops breathing during sleep	A	B	C	D	E	F
2	Has difficulty breathing when asleep	A	B	C	D	E	F
3	Snores	A	B	C	D	E	F
4	Restless sleep	A	B	C	D	E	F
5	Sweating when sleeping	A	B	C	D	E	F
6	Daytime sleepiness	A	B	C	D	E	F
7	Poor Appetite	A	B	C	D	E	F
8	Has Nightmares	A	B	C	D	E	F
9	Sleep walks	A	B	C	D	E	F
10	Sleep talks	A	B	C	D	E	F
11	Screams out in his / her sleep	A	B	C	D	E	F
12	Kicks legs is sleep	A	B	C	D	E	F
13	Wakes up during the night	A	B	C	D	E	F
14	Gets out of bed at night	A	B	C	D	E	F
15	Trouble staying is his / her own bed	A	B	C	D	E	F
16	Resists going to bed at bedtime	A	B	C	D	E	F
17	Grinds his / her teeth	A	B	C	D	E	F
18	Uncomfortable feeling in legs; creepy-crawly feeling	A	B	C	D	E	F
19	Wets Bed	A	B	C	D	E	F

Current Daytime Symptoms

- (A) Never (does not happen)
 (B) Not Often (less than 1 night / day a week)
 (C) Sometimes (1 to 2 nights / days a week)
 (D) Often (3 to 5 nights / days a week)
 (E) Always (6 to 7 nights / days a week)
 (F) Do Not Know

1	Has trouble getting up in the morning	A	B	C	D	E	F
2	Falls asleep at school	A	B	C	D	E	F
3	Naps after school	A	B	C	D	E	F
4	Has daytime sleepiness	A	B	C	D	E	F
5	Feels weak or loses muscles control with strong emotions	A	B	C	D	E	F
6	Reports unable to move when falling asleep or awakening	A	B	C	D	E	F
7	Sees frightening images when falling asleep or awakening	A	B	C	D	E	F

Medical and Psychiatric History

Past Medical History

Frequent Nasal congestion	<input type="checkbox"/>	Yes	Age of diagnosis:
Trouble breathing through nose	<input type="checkbox"/>	Yes	Age of diagnosis:
Sinus problems	<input type="checkbox"/>	Yes	Age of diagnosis:
Chronic bronchitis or cough	<input type="checkbox"/>	Yes	Age of diagnosis:
Allergies	<input type="checkbox"/>	Yes	Age of diagnosis:
Asthma	<input type="checkbox"/>	Yes	Age of diagnosis:
Frequent Colds or Flu	<input type="checkbox"/>	Yes	Age of diagnosis:
Frequent ear infections	<input type="checkbox"/>	Yes	Age of diagnosis:
Frequent Strep throat infections	<input type="checkbox"/>	Yes	Age of diagnosis:
Difficulty swallowing	<input type="checkbox"/>	Yes	Age of diagnosis:
Acid reflux (gastroesophageal reflux)	<input type="checkbox"/>	Yes	Age of diagnosis:
Poor or delayed growth	<input type="checkbox"/>	Yes	Age of diagnosis:
Excessive weight	<input type="checkbox"/>	Yes	Age of diagnosis:
Hearing problems	<input type="checkbox"/>	Yes	Age of diagnosis:
Speech problems	<input type="checkbox"/>	Yes	Age of diagnosis:
Vision problems	<input type="checkbox"/>	Yes	Age of diagnosis:
Seizures / Epilepsy	<input type="checkbox"/>	Yes	Age of diagnosis:
Morning headaches	<input type="checkbox"/>	Yes	Age of diagnosis:
Cerebral palsy	<input type="checkbox"/>	Yes	Age of diagnosis:
Heart disease	<input type="checkbox"/>	Yes	Age of diagnosis:
High blood pressure	<input type="checkbox"/>	Yes	Age of diagnosis:
Sickle cell disease	<input type="checkbox"/>	Yes	Age of diagnosis:
Genetic disease	<input type="checkbox"/>	Yes	Age of diagnosis:
Chromosome problem (e.g., Down's)	<input type="checkbox"/>	Yes	Age of diagnosis:
Skeleton problem (e.g., dwarfism)	<input type="checkbox"/>	Yes	Age of diagnosis:
Cranofacial disorder (e.g., Pierre-Robin)	<input type="checkbox"/>	Yes	Age of diagnosis:
Thyroid problems	<input type="checkbox"/>	Yes	Age of diagnosis:
Eczema (e.g., itchy skin)	<input type="checkbox"/>	Yes	Age of diagnosis:
Pain	<input type="checkbox"/>	Yes	Age of diagnosis:
Head / brain injury	<input type="checkbox"/>	Yes	Age of diagnosis:
Meningitis	<input type="checkbox"/>	Yes	Age of diagnosis:

Past Psychiatric / Psychological History

Autism	<input type="checkbox"/>	Yes	Age of diagnosis:
Developmental Delay	<input type="checkbox"/>	Yes	Age of diagnosis:
Hyperactivity / ADHD	<input type="checkbox"/>	Yes	Age of diagnosis:
Anxiety / Panic attacks	<input type="checkbox"/>	Yes	Age of diagnosis:
Obsessive Compulsive disorder	<input type="checkbox"/>	Yes	Age of diagnosis:
Depression	<input type="checkbox"/>	Yes	Age of diagnosis:
Suicide	<input type="checkbox"/>	Yes	Age of diagnosis:
Learning disability	<input type="checkbox"/>	Yes	Age of diagnosis:
Drug use / abuse	<input type="checkbox"/>	Yes	Age of diagnosis:
Behavioral disorder	<input type="checkbox"/>	Yes	Age of diagnosis:
Psychiatric admission	<input type="checkbox"/>	Yes	Age of diagnosis:

Please list any additional psychological, psychiatric, emotional, or behavioral problems diagnosed or suspected by a physician or psychologist.

Current Medical History

Please list any medications child is currently taking:

Medication	Dose	How Often
1		
2		
3		
4		
5		

Long-Term Medical Problems

If the child has long-term medical problems, please list the three you think are the most important.

1
2
3

Surgeries / Hospitalizations

Has the child had his / her tonsils removed? Yes Age of surgery: _____

Has the child has his her adenoids removed? Yes Age of surgery: _____

Has the child ever had ear tubes? Yes Age of surgery: _____

Please list any additional hospitalizations or surgeries:

1	Age: _____
2	Age: _____
3	Age: _____

Health Habits

Does the child drink caffeinated beverages? (e.g., Coke No Yes Amount per day: _____

Pepsi, Mountain Dew, Orange Soda, Tea, coffee) Time of last drink: _____

School Performance (if school age)

Child's grade:
Has child ever repeated a grade? <input type="checkbox"/> No <input type="checkbox"/> Yes
Is child enrolled in any special education classes? <input type="checkbox"/> No <input type="checkbox"/> Yes
How many school days has child missed this year?
How many school days did child miss last year?
How many school days has child been late this year?
How many school days was child late last year?
Child's grades this year: <input type="checkbox"/> Excellent <input type="checkbox"/> Good <input type="checkbox"/> Average <input type="checkbox"/> Poor <input type="checkbox"/> Failing
Child's grades last year: <input type="checkbox"/> Excellent <input type="checkbox"/> Good <input type="checkbox"/> Average <input type="checkbox"/> Poor <input type="checkbox"/> Failing

Family Information

Pregnancy / Delivery

Pregnancy Normal Difficult

Delivery Term Pre-term Post-term

Child's Birth Weight:

Only child? Yes No If No, circle birth order: 1st 2nd 3rd 4th 5th 6th

Mother	Father
Age: _____	Age: _____
Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Single <input type="checkbox"/> Widowed <input type="checkbox"/> Separated <input type="checkbox"/> Remarried	Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Single <input type="checkbox"/> Widowed <input type="checkbox"/> Separated <input type="checkbox"/> Remarried
Education: _____	Education: _____
Work: <input type="checkbox"/> Unemployed <input type="checkbox"/> Part-time <input type="checkbox"/> Full-time	Work: <input type="checkbox"/> Unemployed <input type="checkbox"/> Part-time <input type="checkbox"/> Full-time
Occupation: _____	Occupation: _____

Persons Living In Home

Name:	Relationship	Age:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Family Sleep History

Does anyone in the child's family have a sleep disorder? No Yes

If Yes, mark the disorders and relationship.

Insomnia	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Brother / sister	<input type="checkbox"/> Grandparent
Snoring	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Brother / sister	<input type="checkbox"/> Grandparent
Sleep Apnea	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Brother / sister	<input type="checkbox"/> Grandparent
Restless Legs Syndrome	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Brother / sister	<input type="checkbox"/> Grandparent
Periodic Limb Movement Disorder	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Brother / sister	<input type="checkbox"/> Grandparent
Sleep walking / sleep terrors	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Brother / sister	<input type="checkbox"/> Grandparent
Sleep talking	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Brother / sister	<input type="checkbox"/> Grandparent
Narcolepsy	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Brother / sister	<input type="checkbox"/> Grandparent
Other: _____	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Brother / sister	<input type="checkbox"/> Grandparent

Is there any other information you think would be helpful for the Physician to know? _____

Reviewed in Detail with Patient and Parent / Guardian

Ronald D. Cates, M.D.

Date: