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Pediatric Sleep/Wake Questionnaire

Sleep Study Date:_____ Sleep Study #:_____

First Name:_____ Last Name:_____

HC#:_____ Gender: Male ☐ Female ☐

Date of Birth: (M/D/Y)_____ Ht:._____cm , Wt: _____kg

Referring Physician_____

General Information:

Questionnaire filled out by: Mom ☐ Dad ☐ Other ☐ Diary Completed? Yes No

What are your major concerns about your child's sleep?

_____

_____

_____

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

If yes: When _____Where _____

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, 7th

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Past Medical History

Frequent nasal congestion	☐ Yes	Age of Diagnosis:
Trouble breathing through his/her nose	☐ Yes	Age of Diagnosis:
Sinus problems	☐ Yes	Age of Diagnosis:
Chronic bronchitis or cough	☐ Yes	Age of Diagnosis:
Asthma	☐ Yes	Age of Diagnosis:
Frequent colds or flu	☐ Yes	Age of Diagnosis:
Frequent ear infections	☐ Yes	Age of Diagnosis:
Frequent strep throat infections	☐ Yes	Age of Diagnosis:
Difficulty swallowing	☐ Yes	Age of Diagnosis:
Acid reflux (gastro-esophageal reflux)	☐ Yes	Age of Diagnosis:
Poor or delayed growth	☐ Yes	Age of Diagnosis:
Excessive weight	☐ Yes	Age of Diagnosis:
Hearing problems	☐ Yes	Age of Diagnosis:
Speech problems	☐ Yes	Age of Diagnosis:
Vision problems	☐ Yes	Age of Diagnosis:
Seizure/Epilepsy	☐ Yes	Age of Diagnosis:
Morning headaches	☐ Yes	Age of Diagnosis:
Cerebral palsy	☐ Yes	Age of Diagnosis:
Heart disease	☐ Yes	Age of Diagnosis:
High blood pressure	☐ Yes	Age of Diagnosis:
Sickle cell disease	☐ Yes	Age of Diagnosis:
Genetic disease	☐ Yes	Age of Diagnosis:
Chromosome problem (e.g. Down's)	☐ Yes	Age of Diagnosis:
Skeleton problem (e.g. dwarfism)	☐ Yes	Age of Diagnosis:
Craniofacial disorder (e.g. Pierre Robin)	☐ Yes	Age of Diagnosis:
Thyroid problems	☐ Yes	Age of Diagnosis:
Eczema (itchy skin)	☐ Yes	Age of Diagnosis:
Pain	☐ Yes	Age of Diagnosis:
Allergies If yes to what:	☐ Yes	Age of Diagnosis:

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Past Psychiatric/Psychological History

Autism	☐ Yes	Age of Diagnosis:
Developmental delay	☐ Yes	Age of Diagnosis:
Hyperactivity/ADHD	☐ Yes	Age of Diagnosis:
Anxiety/panic attacks	☐ Yes	Age of Diagnosis:
Obsessive compulsive disorder	☐ Yes	Age of Diagnosis:
Depression	☐ Yes	Age of Diagnosis:
Suicidal tendencies	☐ Yes	Age of Diagnosis:
Learning disability	☐ Yes	Age of Diagnosis:
Drug use/abuse	☐ Yes	Age of Diagnosis:
Behavioral disorder	☐ Yes	Age of Diagnosis:
Psychiatric admission	☐ Yes	Age of Diagnosis:

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

_____

Has your child had?

Tonsils removed	☐ Yes	☐ No	If yes at what age _____
Adenoids removed	☐ Yes	☐ No	If yes at what age _____
Craniofacial procedures	☐ Yes	☐ No	If yes at what age _____
Head/face trauma	☐ Yes	☐ No	If yes at what age _____

Other procedures: _____

Current Medication(s)

Medication	Dosage	Last Time Taken

Does your child drink caffeinated beverages (iced tea, Coke, Pepsi)? ☐ Yes ☐ No
If yes, what is the amount per day? _____

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Current School Performance

Your child is in what grade? _____

Has your child ever repeated a grade? ☐ Yes ☐ No

Is your child enrolled in any special education class? ☐ Yes ☐ No

How many school days has your child missed so far this year? _____

How many school days was your child late so far this year? _____

How many school days was your child late last year? _____

Child's grades this year: ☐ Excellent ☐ Good ☐ Average ☐ Poor ☐ Failing

Child's grades last year: ☐ Excellent ☐ Good ☐ Average ☐ Poor ☐ Failing

Sleep History:

1. Does your child Nap during the day? ☐ Yes ☐ No
   If yes: How often?_____
   How long?_____
2. What time does your child normally go to sleep?_____
3. How many hours of sleep does your child get most nights?_____
4. How long does it usually take for your child to fall asleep?_____
5. Does your child sleep in his/her own bed? _____
   _____

Snoring

Does your child snore: ☐ Yes ☐ No

If Yes: How many times/week? _____
Is the snoring continuous? ☐ Yes ☐ No
How would you rate the snoring? ☐ mild ☐ moderate
☐ loud ☐ very loud
At what age did the snoring start? _____

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Answer the following questions using the following rating

Never:	not at all
Rarely:	1-3 nights per month
Sometimes:	3-4 nights per month
Often	Almost every night

Breathing during sleep: Does your child?

	Never	Rarely	Sometimes	Often
Appears to be struggling to breathe during sleep	☐	☐	☐	☐
Mouth breathe	☐	☐	☐	☐
Gasp for air	☐	☐	☐	☐
Make choking sounds	☐	☐	☐	☐
Make other noises when breathing	☐	☐	☐	☐
Stop breathing during sleep	☐	☐	☐	☐
Have blue spells	☐	☐	☐	☐
Appear congested	☐	☐	☐	☐
Have restless sleep	☐	☐	☐	☐

Behaviors During sleep: Does your child**?**

	Never	Rarely	Sometimes	Often
Wake up more than twice/night	☐	☐	☐	☐
After waking has trouble falling asleep again	☐	☐	☐	☐
Twitches or jerks legs	☐	☐	☐	☐
Has excessive night sweats (soaks sheets)	☐	☐	☐	☐
Sleep walks	☐	☐	☐	☐
Sleep talks	☐	☐	☐	☐
Grinds teeth	☐	☐	☐	☐
Wakes up crying and upset	☐	☐	☐	☐
Nightmares	☐	☐	☐	☐
Rocks body	☐	☐	☐	☐
Bangs head	☐	☐	☐	☐
Vomits	☐	☐	☐	☐
Coughs	☐	☐	☐	☐
Wets the bed	☐	☐	☐	☐

If yes, has your child ever been "dry" at night? _____

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In the morning, does your child?	**Never**	**Rarely**	**Sometimes**	**Often**
Have difficulties waking up	☐	☐	☐	☐
Wake up feeling tired	☐	☐	☐	☐
Have difficulties moving upon awaking	☐	☐	☐	☐
Have headaches	☐	☐	☐	☐

During the day, does your child?	**Never**	**Rarely**	**Sometimes**	**Often**
Get sleepy	☐	☐	☐	☐
Suddenly falls asleep at inappropriate times e.g. at school, watching TV	☐	☐	☐	☐
Becoming physically tired	☐	☐	☐	☐
Napping after school	☐	☐	☐	☐

Family History

Does anyone in the family have a sleep disorder?	☐ Yes	☐ No		
If yes, mark the disorder(s):				
Insomnia	☐ Mother	☐ Father	☐ Brother/Sister	☐ Grandparent
Snoring	☐ Mother	☐ Father	☐ Brother/Sister	☐ Grandparent
Sleep apnea	☐ Mother	☐ Father	☐ Brother/Sister	☐ Grandparent
Restless leg syndrome	☐ Mother	☐ Father	☐ Brother/Sister	☐ Grandparent
Periodic limb movement disorder	☐ Mother	☐ Father	☐ Brother/Sister	☐ Grandparent
Sleepwalking/sleep terrors	☐ Mother	☐ Father	☐ Brother/Sister	☐ Grandparent
Sleep talking	☐ Mother	☐ Father	☐ Brother/Sister	☐ Grandparent
Narcolepsy	☐ Mother	☐ Father	☐ Brother/Sister	☐ Grandparent
Other:	☐ Mother	☐ Father	☐ Brother/Sister	☐ Grandparent

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Modified Epworth Sleepiness Scale

How likely are you/your child to doze off or fall asleep in the following situations, in contrast to feeling just tired? This refers to your usual way of life in recent times. Even if you/your child have not done some of these things recently, try to work out how they would have affected you/your child. Use the following scale to choose the most appropriate number for each situation.

0 = no chance of dozing

1 = slight chance of dozing

2 = moderate chance of dozing

3 = high chance of dozing

Situation	Chance of dozing
Sitting and reading	
Watching TV	
Sitting inactive in a public place (eg movie theater or a meeting)	
As a passenger in a car/bus for an hour without a break	
Lying down to rest in the afternoon when circumstances permit	
Sitting and talking to someone	
Sitting quietly after lunch	
In a car/bus, while stopped for a few minutes in traffic	