M I L L E R C H I L D R E N ' S H O S P I T A L
S L E E P D I S O R D E R S C E N T E R
2651 ELM AVE # 205
L O N G B E A C H , C A 9 0 8 0 6
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Patient/Parent Questionnaire
Sleep Clinic

Child's Name: **Age:** **Date of Birth**:

Male ☐ **Female ☐**

Name of person completing this questionnaire:

Relationship to child: **Date:**

PREGNANCY/ DELIVERY

Was your pregnancy healthy?	Yes ☐ No☐	If no, please explain:	
Length of pregnancy?			
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 wakings 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?	❒ No	❒ Yes	If Yes, date: (month/year)
Surgery to remove adenoids?	❒ No	❒ Yes	If Yes, date: (month/year)

CHILD'S SLEEP/WAKE SCHEDULE

Is your child's sleep routine regular? Yes☐ No☐

School or Weekdays		
Usual Bedtime:	Time When Child Really Falls Asleep:	Usual Wake Time:
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	☐
Back and side or stomach	☐
All positions	☐
Sitting up or propped up with pillows	☐
Not sure	☐
***Where** does your child **fall** sleep?*	
Own bed	☐
Own room	☐
Some one else's bed	☐ With whom?
Some one else's room	☐ With whom?
Where does your child sleep most of the night?	
***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?	
***Where** does your child sleep for **most of the night**?*	
Describe:	

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	Problem 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	☐	☐	☐	☐	☐	☐

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

Activities	Very sleepy	Falls Asleep	No Problem	Not Applicable	Problem Yes	Problem 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)*	☐	☐	☐	☐	☐	☐

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

	No	Yes	Unsure
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 days	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:	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)	☐	☐	☐

☺ You're done! **Thanks** for all your time! The more information we have, the easy it is to diagnose your child's sleep problems. If you have anything else you want to tell us about your child's health, have comments about this questionnaire, or if some the questions were confusing or had words you didn't understand, please tell us.

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____