Miller Children's Hospital Long Beach

OUTPATIENT SPECIALITY CLINIC
STRAMSKI CHILDREN'S DEVELPOMENTAL CENTER

2651 Elm Ave #205 Long Beach Ca 90806 562-728-5034 Phone 562-490-9413 Fax

Pre-Admission Form

(Please fill out all sections completely and accurately) Intaker's Initials:___________
Today's Date:________________ Appointment Date:______________Time: ________am/pm
Referred to MD:______________ Referring MD: ________________________ Telephone: ________

Patient Information
Patient's Last Name: ____________________________ First Name:____________________ MI:________
DOB: ____________ Sex: M / F Alias:____________________
Address: ________________________________Apt #: ______ City: ___________________ Zip: ________
Home Telephone #: _______________________ May we leave a message on this number? Y N
SSN: _____-____-___________ Language: ___________ Race: __________Religion: _______________
Primary Caretaker: _______________________ Relationship to Patient: ____________________
Cell #: ____________________________ May we leave a message on this number? Y N
Email: ____________________________ May we contact you on this address? Y N
Secondary Caretaker: _____________________ Relationship to Patient: ____________________
Cell #: ____________________________ May we leave a message on this number? Y N
Email: ____________________________ May we contact you on this address? Y N

In case of an emergency *(Someone other than parents)*
Emergency Contact Name: _____________________________ Day Telephone: (____)______-__________
Relationship to Patient: ____________________ Home Telephone: (____)_____-__________

Responsible Party (Guarantor) *(Is Caretaker 1 or Caretaker 2 the Guarantor? If so indicate "same as above")*
Last Name: ____________________________________ First Name: ______________________
Address *(if different from above)*: ____ Zip:______________
Home Telephone #: _____________________________ Work Telephone #: ____________________
Cell Telephone #: _______________________________DOB: ____________
Sex: M / F SSN: ______-_____-___
Employed by: ____
Employer's Address: ____

Primary Insurance Information *(send copy of insurance card)*
Insurance Type: ☐HMO ☐MCAL ☐MCAL HMO ☐CCS ☐PPO ☐EPO ☐POS ☐Other________
Insurance Name: _________________________ IPA/Medical Group: ___________________
Telephone: __________________ Fax: ___________________
Claims Mailing Address: ____ City: _____________
Subscriber: ______________________________ SSN: ______-_____-_________Group #:__________
Eligibility Date: __________________________ Deductible/Share of Cost/Co-pay: $_______
Primary Care Provider: __________________________ Address: ____________________________
City: ______________________ State: ______ Zip:________ Telephone: (____)_____-____
Fax #: (_____)_____-__________ Authorization #: ______________________ Expiration: ______________
Authorization Form Attached: Yes / No Parent to Bring Authorization Yes / No

MemorialCare Sleep Disorders Center
Pediatric Division

Sleep Lab

Patient/Parent Questionnaire for Sleep Study

Child's Name: ________________________________ **Male ☐ Female ☐**

Date of Birth: ________________ **Age:**_________

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?	Number of weeks:		
Mode of delivery	Vaginal ☐	C-section ☐	Vacuum assist ☐
After delivery, were there any problems with your baby?	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)

Reviewed for completeness ________
PSC 2003Eeng_abridged

Rev 1-16

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)
____
____
____

SLEEP SYMPTOMS OR PROBLEMS

If you consider a symptom being a problem or concern for you, please place a check under the Problem* column

	Usually (5-7/wk)	Sometimes (2-4/wk)	Rarely (0-1/wk)	Never	*Problem
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 grinds teeth during sleep (dentist may have told you this)	☐	☐	☐	☐	☐
Child snores loudly	☐	☐	☐	☐	☐
Child seems to stop breathing during sleep	☐	☐	☐	☐	☐
Child snorts and/or gasps during sleep	☐	☐	☐	☐	☐
Child awakens during night screaming, sweating and inconsolable	☐	☐	☐	☐	☐
Child awakens alarmed by a frightening dream	☐	☐	☐	☐	☐
Child is very sweaty during sleep	☐	☐	☐	☐	☐
Child complains of weird feelings or "growing pains" in his/her legs at night	☐	☐	☐	☐	☐

Reviewed for completeness ________

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 (eg – 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	☐	☐	☐
Anxiety problems	☐	☐	☐
Behavioral or emotional problems	☐	☐	☐
Obsessive compulsive disorder	☐	☐	☐
Depression	☐	☐	☐
Suicide attempts	☐	☐	☐
Drug abuse	☐	☐	☐
Admissions to hospital for psychiatric (mental health) problems	☐	☐	☐

Reviewed for completeness ________

☺ You're done! **Thanks** for all your time! The more information we have, the easy it is to interpret your child's sleep study. 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.

____
____
____
____
____
____
____
____
____
____

Reviewed for completeness ________