



PEDIATRIC/ADOLESCENT QUESTIONNAIRE

FOR PARENT & CHILD/ADOLESCENT TO COMPLETE

NAME _____ AGE _____

BIRTH DATE (MM/DD/YYYY) _____ TODAY'S DATE _____

GRADE _____

PRIMARY CARE PHYSICIAN _____

REFERRING SPECIALIST _____

REASON FOR BEING HERE/BRIEFLY DESCRIBE THE PROBLEM OR CONCERN BELOW:

SLEEP HISTORY

AMOUNT OF SLEEP

BED TIME _____ WAKE-UP TIME _____ (SCHOOL DAYS)

BED TIME _____ WAKE-UP TIME _____ (DAYS OFF)

TIME IT TAKES TO FALL ASLEEP _____

AMOUNT OF TIME SLEEPING PER DAY _____

BREATHING DURING SLEEP

CIRCLE all that apply:

- | | | |
|----------|---------------------|------------------|
| SNORING | NOISY BREATHING | STOPS BREATHING |
| RESTLESS | IRREGULAR BREATHING | UNUSUAL POSITION |

MOVEMENT AND BEHAVIOR DURING SLEEP

CIRCLE all that apply:

- | | | |
|-----------------------------|------------------------|---------------|
| DISCOMFORT IN LEGS AND ARMS | EXCESSIVE LEG MOVEMENT | SLEEP WALKING |
| HEAD BANGING/BODY ROCKING | BAD DREAMS | SLEEP TERRORS |
| ACTING OUT DREAMS | TEETH GRINDING | BED WETTING |
| SEIZURES | | |

SLEEP PHYSICIAN'S COMMENTS:



DAY TIME FUNCTION

CIRCLE all that apply:

EXCESSIVE DAYTIME SLEEPINESS

DIFFICULTY GETTING UP IN AM

DOZING AT SCHOOL

AFTER SCHOOL FATIGUE

NAPPING

POOR SCHOOL WORK

SHORT ATTENTION SPAN

HYPERACTIVE

DISTRACTIBLE

SLEEP PHYSICIAN COMMENTS:

MEDICAL HISTORY

List all that apply:

MEDICATIONS _____

ALLERGIES _____

CHRONIC MEDICAL PROBLEMS _____

EAR, NOSE AND THROAT PROBLEMS _____

APPETITE AND GROWTH PROBLEMS _____

FAMILY HISTORY

<i>Relative</i>	<i>Sleep Disorder Y or N</i>	<i>Type</i>
Mother	_____	_____
Father	_____	_____
Grandparents	_____	_____
Siblings	_____	_____

Major Illnesses in Family: _____

Household Members:

SLEEP PHYSICIAN COMMENTS:

PHYSICAL EXAM

HT _____ WT _____ BMI _____ BP _____ HR _____ SAO2 _____

ENT _____ CARDIORESPIRATORY _____

NEUROLOGIC/BEHAVIORAL _____ OTHER _____