PEDIATRIC SLEEP QUESTIONNAIRE

COMPLETED BY (name):

YOUR RELATIONSHIP TO THE PATIENT:

Patient Age:
Patient Height:
Patient Weight:

Thank you completing this questionnaire. While there are many questions on this survey, it will help guide the sleep consultation. Many questions will be clarified during the visit as well, so if you are unsure of answers, just do your best. The sleep clinician will probably ask you to elaborate on several of the issues, and you should feel encouraged to tell him/her anything else which is not included here, but which you think might be important to the evaluation

1. REASON FOR CONSULTATION

Please briefly describe the problem for which you are seeking a sleep consultation:

_____
_____
_____
_____

GENERAL MEDICAL HISTORY

2. PREGNANCY & DELIVERY

A. Did you have any illnesses or complications during this pregnancy? If so, what were they?

_____
_____

B. Was your child born full term (37-40 weeks)? (Y/N) ___ If no, how many weeks? ____
C. Was delivery vaginal? (Y/N) ____
If Cesarean section, what were the indications? _____
D. How long was the labor? _____ Birth weight? _____
E. When your child was born, did he/she cry right away? (Y/N) _____
F. Did your child have to go to the neonatal intensive care unit? (Y/N) _____
Describe any problems your child had in the first few days after birth.

_____
_____
_____

3. GENERAL HEALTH

Aside from the usual colds and flu, has your child had any special health problems, major illnesses, surgery, etc.? (Y/N) _____

If so, please describe:

_____
_____

4. DEVELOPMENT

How old was your child when he/she first did the following (if applicable)?

Smiled responsively	_____	Walked downstairs	_____
Rolled over	_____	Rode a tricycle	_____
Sat unaided	_____	Rode a bicycle	_____
Crawled	_____	Said first words	_____
Pulled to stand	_____	Put 2 or 3 words together	_____
Walked	_____	Began to help in dressing	_____
Ran	_____	Dressed self independently	_____
Walked upstairs	_____	Tie shoelaces independently	_____

Handedness (right, left, ambidextrous) _____ became apparent at age: _____

5. SCHOOLING

A. Is your child attending school? (Y/N) _____
B. What grade is your child in now (if applicable)? _____
C. Is there an individualized education plan (IEP)? _____
D. What school do they attend? _____
E. How are his/her grades? _____
F. Are there any behavior or attention problems at school? (Y/N) _____
If yes, when did this start? _____

6. FAMILY

A. Please list the names and ages of brothers and sisters in chronological order

Name	Age	Brother/ sister	Specific health/sleep condition (please specify)

B. On either side of the family, has anyone ever experienced any of the following conditions: (Please circle or bold all that apply and explain below):

- o Sudden infant death
- o Epilepsy
- o Seizures
- o Paralysis
- o Delay/retardation
- o Cerebral palsy
- o Learning disabilities
- o Hyperactivity
- o Tumor
- o Sleep problems
- o Other neurologic condition (please specify): _____

If any condition was circled/bolded above, please explain: _____
_____
_____

C. Describe any other medical conditions which run in the family:
_____
_____

D. Have there been any divorces, deaths, or other relevant family problems which might affect the child?
_____If so, please explain: _____

_____

7. REVIEW OF SYSTEMS

Please check if your child has had a problem with any of the following:

_____ headaches _____ poor or double vision
_____ impaired vision _____ speech/ language problems
_____ weakness _____ incoordination/ clumsiness
_____ lethargy/ sleepiness _____ hyperactivity
_____ vomiting _____ seizures or convulsions
_____ a heart condition _____ a problem with stomach/ intestines
_____ dizziness _____ a problem with kidneys or bladder
_____ allergies (to what?) _____
_____ other (explain) _____

8. MEDICATIONS

Please list all the medications, vitamins, and supplements that your child is currently taking including name, dosage, frequency, and time:

	Medication	Dose	Frequency	Time
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				

9. OTHER

If you have any further notes that you may not want to forget to tell the doctor, please write it down here:
_____
_____
_____
_____

SPECIFIC PEDIATRIC SLEEP QUESTIONS

What are the specific sleep issues that have led to the referral and questions that you wish to address?

1. _____
2. _____
3. _____

Please describe the impact of sleep issues on parents, family, and school:

_____

_____

o Child sleeps alone (Y/N) _____ o Child co-sleeps with parent(s) or caregiver (Y/N) _____ o Child sleeps with sibling (Y/N) _____		
WEEKEDAYS: Usual bedtime:	Wake time:	Nap time:
WEEKENDS: Usual bedtime:	Wake time:	Nap time:

Please describe the patient's bedtime routine: (time that bedtime routine starts, length of bedtime routine, parent participation, need of objects to help them sleep, etc.)

_____

_____

_____

_____

a. Is the bedtime routine adhered to consistently?	_____ Yes	_____No
b. Do you experience bedtime struggles with your child?	_____ Yes	_____No
c. Does your child settle quickly with caregiver intervention?	_____ Yes	_____No
d. Does your child express fear going to sleep?	_____ Yes	_____No
e. Does your child experience head banging, racking?	_____ Yes	_____No
f. Does your child stay awake > 1 hour before falling asleep?	_____ Yes	_____No
g. Does your child awaken crying, fearful, or confused?	_____ Yes	_____No
Are there any unusual behaviors that disrupts the patient's sleep? How many times per week: _____ First half of the night (Y/N) __ Last half of night (Y/N) ___ Does the child appear o Confused? (Y/N) _____ o Disoriented? (Y/N) _____ o Aggressive? (Y/N) _____ o Scared? (Y/N) _____ o Does the child remember the episode? (Y/N/Unsure) _____ o Please elaborate:		

Does child experience any of the following? For all that apply, please note their frequency:

Behavior	Frequency (nights/week)	Behavior	Frequency (nights/week)
Snoring		Difficulty waking up in the morning	
Pauses in breathing		Waking up too early	
Bedwetting		Disturbing other's sleep	
Sleep talking		Daytime irritability	
Sleepwalking		Daytime spells	
Sleep paralysis		Impulsiveness	
Nocturnal seizures		Depressed mood	
Grinding teeth		Behavior problems	
Nightmares		Learning problems	
Asthma attacks at night		Poor peer interactions	
Restless sleeper		Short attention span	
Light sleeper			
Heavy sleeper			

UCLA Health System

MRN:
Patient Name:

A. Nighttime and sleep behavior WHILE SLEEPING, DOES YOUR CHILD …	Yes	No	Don't know
… ever snore?			
… snore more than half the time?			
… always snore?			
… snore loudly?			
… have "heavy" or loud breathing?			
… have trouble breathing, or struggle to breathe?			
HAVE YOU EVER ...			
… seen your child stop breathing during the night? If so, please describe what happened:			
… been concerned about your child's breathing during sleep?			
… had to shake your sleeping child to get him or her to breathe, or wake up and breathe?			
… seen your child wake up with a snorting sound?			
DOES YOUR CHILD …			
… have restless sleep?			
… describe restlessness of the legs when in bed?			
… have "growing pains" (unexplained leg pains)?			
… have "growing pains" that are worst in bed?			
WHILE YOUR CHILD SLEEPS HAVE …			
… brief kicks in one or both legs?			
… repeated kicks or jerks of the legs at regular intervals (i.e. about every 20 to 40 seconds)?			

AT NIGHT, DOES YOUR CHILD USUALLY …	Yes	No	Don't know
… become sweaty, or do the pajamas usually become wet with perspiration?			
… get out of bed (for any reason)?			
… get out of bed to urinate? If so, how many times each night, on average? _____			
… sleep with the mouth open?			
Is your child's nose usually congested or "stuffy" at night?			
Do allergies affect your child's ability to breath to the nose?			
DOES YOUR CHILD …			
… tend to breathe through the mouth during the day?			
… have a dry mouth on waking up in the morning?			
… complain of an upset stomach at night?			
… get a burning feeling in the throat at night?			
… grind his or her teeth at night?			
… occasionally wet the bed?			
Has your child ever walked during sleep ("sleep walking")?			
Have you ever heard your child talk during sleep ("sleep talking")?			
Does your child have nightmares once a week or more on average?			
Has your child ever woken up screaming during the night?			
Has your child ever been moving or behaving, at night, in a way that made you think your child was neither completely awake nor asleep? If so, please describe what has happened:			
Does your child have difficulty falling asleep at night?			
How long does it take your child to fall asleep at night?			
At bedtime does your child usually have difficult "routines" or "rituals," argue a lot, or otherwise behave badly?			

AT NIGHT, DOES YOUR CHILD USUALLY …	Yes	No	Don't know
… bang his or her head or rock his or her body when going to sleep?			
… wake up more than twice a night on average?			
… have trouble falling back asleep if he or she wakes up at night?			
… wake up early in the morning and have difficulty going back to sleep?			
Does the time at which your child goes to bed change from day to day?			
Does the time at which your child gets up from bed change from day to day?			
WHAT TIME DOES YOUR CHILD USUALLY …			
… go to bed during the week?			
… go to bed on the weekend or vacation?			
… get out of bed on weekday mornings?			
… get out of bed on weekends or vacation mornings?			
B. Daytime behavior and other possible problems: DOES YOUR CHILD …			
… wake up feeling unrefreshed in the morning?			
… have a problem with sleepiness during the day?			
… complain that he or she feels sleepy during the day?			
Has a teacher or other supervisor commented that your child appears sleepy during the day?			
Does your child usually take a nap during the day?			
Is it hard to wake your child up in the morning?			
Does your child wake up with headaches in the morning?			
Does your child get a headache at least once a month, on average?			
Did your child stop growing at a normal rate at any time since birth? If so, please describe what happened:			

	Yes	No	Don't know
Does your child still have tonsils? If not, when and why were they removed?			
HAS YOUR CHILD EVER …			
… had a condition causing difficulty with breathing? If so, please describe:			
… had tonsillectomy/adenoidectomy surgery? If so, did any difficulties with breathing occur before, during, or after surgery?			
… become suddenly weak in the legs, or anywhere else, after laughing or being surprised by something?			
… felt unable to move for a short period, in bed, though awake and able to look around?			
Has your child felt an irresistible urge to take a nap at times, forcing him or her to stop what he or she is doing in order to sleep?			
Has your child ever sensed that he or she was dreaming (seeing images or hearing sounds) while still awake?			
(If age appropriate) Does your child drink caffeinated beverages on a typical day (cola, tea, coffee, decaffeinated drinks, chocolate)? If so, how many cups or cans per day?			
(If age appropriate) Does your child use any recreational drugs? If so, which ones and how often?			
(If age appropriate) Does your child smoke, vape, or snuff tobacco? If so, which ones and how often?			

HAS YOUR CHILD EVER …	**Yes**	**No**	**Don't know**
Is your child overweight? If so, at what age did this first develop?			
Has a doctor ever told you that your child has a high-arched palate (roof of the mouth)?			
Has your child ever taken ADHD medications, like Ritalin (methylphenidate), for behavioral problems?			
Has a health professional ever said that your child has attention-deficit disorder (ADD) or attention deficit/hyperactivity disorder (ADHD)?			

Modified Pediatric Epworth Sleepiness Scale (if your child is < 7 years old, leave blank)

How likely are you 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 have not done some of these things recently, think about how they would affected you. Use the following scale to choose appropriate number for each situation. From: Johns MW. A New method for measuring daytime sleepiness; the Epworth sleepiness scale. Sleep 1991;14:540545 Moore M, Journal of Pediatric Psychology, 2009;34:1175-1183

0 = no chance of dozing
1 = slight chance of dozing
2 = moderate chance of dozing
3 = high chance of dozing

Situation	0	1	2	3
Sitting and reading	☐	☐	☐	☐
Watching television	☐	☐	☐	☐
Sitting inactive in a public place (i.e. a movie theater or classroom)	☐	☐	☐	☐
As a passenger in a car for an hour without a break	☐	☐	☐	☐
Lying down to rest in the afternoon	☐	☐	☐	☐
Sitting and talking to someone	☐	☐	☐	☐
Sitting quietly after lunch	☐	☐	☐	☐
Doing homework or taking a test	☐	☐	☐	☐

Total Score: ___