Workstation: _____ Site: _____ Date:_____

Referring Physician:_____Family Physician (PCP):_____

Please complete the following questionnaire by filling in the blanks and placing a check in appropriate areas.

My Child's Sleep Complaint(s) Is:

- ☐ Trouble sleeping
- ☐ Being sleepy all day
- ☐ Snoring
- ☐ Unwanted behaviors during sleep, explain_____

☐ Other, explain_____

Sleep Pattern

Typical bedtime: _____a.m./p.m.
Typical time my child gets out of bed: _____a.m./p.m.

Please check all of the following statements that are true about your child's sleep.

Sleep Habits

- ☐ He/she usually watches TV or reads in bed prior to sleep.
- ☐ He/she typically wakes up from sleep to go to the bathroom.
- ☐ He/she has trouble falling asleep.
- ☐ He/she often wakes up during the night.
- ☐ He/she has nightmares.
- ☐ He/she wets the bed.
- ☐ He/she sleep walks.
- ☐ He/she wakes up groggy.
- ☐ He/she wakes up refreshed.
- ☐ He/she wakes up screaming and cannot be consoled.
- ☐ He/she wakes up and feels like he/she is paralyzed.

Sleep Position

- ☐ Back
- ☐ Side
- ☐ Stomach

Breathing

- ☐ He/she stops breathing while asleep.
- ☐ He/she wakes up at night choking or gasping for air.
- ☐ He/she snores.
- ☐ He/she snores only when sleeping on his/her back.

Restlessness

☐ He/she kicks or jerks his/her legs during sleep.
☐ He/she grinds his/her teeth during sleep.
☐ He/she tosses and turns during sleep.

Daytime Sleepiness

☐ He/she has trouble doing school work because of sleepiness.
☐ He/she has fallen asleep while in school.
☐ He/she takes naps.

Habits

He/she drinks caffeinated beverages during the day: _____cups/bottles/cans per day.

Status:

☐ He/she is currently a student.

Medical History

Vital Statistics

What is your: Height? _____feet _____inches. Weight? _____pounds. Neck Size?_____inches.
Did he/she have a weight change over the last 5 years? Gain _____lbs. Lost _____lbs.

Allergies: _____

_____

Past Medical History

☐ Hypertension (high blood pressure)
☐ Heart Disease
☐ Diabetes (insulin dependent)
☐ Lung problems/ asthma
☐ Reflux
☐ Seizures
☐ Depression or severe anxiety
☐ Hearing impairment
☐ Stomach or colon problems
☐ Irregular heartbeat
☐ Prematurity
Birth weight _____lbs. _____oz.

List other medical problems

_____ _____

_____ _____

_____ _____

_____ _____

PATIENT INFORMATION

PINNACLEHEALTH Hospitals

SLEEP CENTER
PEDIATRIC SLEEP QUESTIONNAIRE

SL1002

Surgeries

☐ Tonsillectomy

Medication List

Patient Signature:_____ Printed Name:_____ Date:_____ Time:_____

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