



Deaconess
Sleep Center
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PEDIATRIC SLEEP EVALUATION QUESTIONNARE

me: DOB:				
Address:				
City:	State:	Zip: _		
Day Phone #:	Evening Phone #	#:		
Height: Weight:	School Grade:	Sex:	Male Female	
Parent/Guardian Name(s):				
Please describe your child's sleep p	roblem in your own words:			
	CHILD'S SLEEP HISTORY			
Weekday Sleep Schedule: Total amount of time the o	child sleeps during a 24 hour period	d on weekdays:		
Child's normal bedtime on Child's normal wake time			 :	
Weekend or Vacation Sleep Schedu Total amount of time the o	ıle: child sleeps in 24 hr period during v	weekends or vac	ation days:	
Child's normal bedtime on Child's normal wake time				
Nap Schedule: Number of days per week	the child takes a nap:	-4 -5	- 6 - 7	
What is your child's usual	nap time?:::		:	
General Sleep: Does the child have a regulation Does the child have his/her ov Is a parent/guardian present Does the child listen to race	er own bed? wn bedroom? ent when child falls asleep?	□ Yes □ Yes □ Yes □ Yes □ Yes □ Yes	□ No □ No □ No □ No □ No	
Child usually falls asleep:	Child sleeps most of the night:	Child usually	wakes in morning:	
own room in own bed (alone) parent's room in own bed parent's room in parent's bed sibling's room in own bed sibling's room in sibling's bed	□ own room in own bed (alone) □ parent's room in own bed □ parent's room in parent's bed □ sibling's room in own bed □ sibling's room in sibling's bed	□ parent's roo □ parent's roo □ sibling's roo	in own bed (alone) om in own bed om in parent's bed om in own bed om in sibling's bed	

CHILD'S MEDICAL HISTORY

PAST MEDICAL HISTORY- Does your child have/had any of the following:					
Was your child born premature?	□ Yes	□ No			
If so, how many weeks premature?		<u> </u>			
Colic as an infant?	□ Yes	□ No			
Frequent nasal congestion	□ Yes	□ No			
Trouble breathing through their nose	□ Yes	□ No			
Sinus problems	□ Yes	□ No			
Chronic bronchitis or cough	□ Yes	□ No			
Allergies	□ Yes	□ No			
Asthma or other chronic breathing disorder	□ Yes	□ No			
Frequent ear infections	□ Yes	□ No			
Acid reflux (GERD)	□ Yes	□ No			
Difficulty swallowing	□ Yes	□ No			
Obesity	□ Yes	□ No			
Hearing problems	□ Yes	□ No			
Speech problems	□ Yes	□ No			
Vision problems	□ Yes	□ No			
Seizures/epilepsy	□ Yes	□ No			
Morning headaches	□ Yes	□ No			
Cerebral palsy	□ Yes	□ No			
High blood pressure	□ Yes	□ No			
Thyroid problems	□ Yes	□ No			
Eczema (e.g. itchy skin)	□ Yes	□ No			
RSV	□ Yes	□ №			
Head/brain injury	□ Yes	□ №			
Heart problems	□ Yes	□ No			
Gastrointestinal problems	□ Yes	□ No			

PAST PSYCHIATRIC/ PSYCHOLOGICAL HISTORY- Does your child have/had any of the following:					
Autism	□ Yes	□ No			
Developmental Delay	□ Yes	□ No			
Hyperactivity or ADHD	□ Yes	□ No			
Anxiety or Panic Attacks	□ Yes	□ No			
Obsessive Compulsive Disorder	□ Yes	□ No			
Oppositional Defiant Disorder	□ Yes	□ No			
Depression	□ Yes	□ No			
Suicide	□ Yes	□ No			
Learning disability	□ Yes	□ No			
Drug use or abuse	□ Yes	□ No			
Behavioral disorder	□ Yes	□ No			
Psychiatric disorder	□ Yes	□ No			
Please list any additional psychological, psychiatric, emosuspected by a physician or psychologist:	ptional, or behavioral probl	ems diagnosed or			

If yes, please list medication, dose, at what time given, and what for:						
Has your child had a tonsillectomy?	□ Yes	□ No	if yes, w	hen?		
Has your child had an adenoidectomy?	□ Yes	□ No	if yes, w	hen?		
Has your child had ear tubes placed?	□ Yes	□ No	if yes, w	hen?		
Had any other surgeries? 🗆 Yes 🗀 No	if yes, p	lease sp	ecify			
On average, how many caffeinated beve	erages (ex. s	oda, tea	, coffee, e	nergy drir	nks) does your	child drink?
Daily: Weekly:	_ At what tir	ne durin	g the day	l		
Has a teacher ever been concerned with	your child b	eing sle	epy or ina	ttentive a	t school? Yes	□ No
Has your child ever fallen asleep in scho	ool?				□ Yes	□ No
What time of day does your child seem	most alert?				□ AM	□ PM
Have you ever used medications to aid i	n your child'	s sleep?			□ Yes	□ No
If so, please list what drug and	when?					
Do you consider your child's sleep probl	em to be:			□ Mild	□Moderate	□ Severe
Has your child ever become weak or un	steady when	excited,	, surprised	, or emoti	onal? 🗆 Yes	□ No
Has your child ever seemed to lose cont involuntarily?	rol of his/hei	r arms (dropping o	bjects) or	· legs (stumblin Yes	g) □ No
Does your child wet the bed?					□ Yes	□ No
If so, how many times per wee	k? □1	□ 2	□ 3	□ 4	□ 5 □ 6	7
Does your child sleep walk?	ever 🗆 Rar	ely 🗆	Occasiona	lly □ Fr	equently 🗆 A	lways
If you child sleep walks, has he	e/she ever in	jured th	eir selves?		□ Yes	□ No
Does your child talk in their sleep?					□ Yes	□ No
Does your child ever rock his/her body w	when asleep?)			□ Yes	□ No
Does your child ever bang his/her head	on the pillow	when a	isleep?		□ Yes	□ No
Does anyone in the family have obstruc	tive sleep ap	nea or u	ise CPAP o	r BIPAP w	hile sleeping?	□ No