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Complete Sleep
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DW Henninger MD Medical Director
Board Certified Pulmonary & Sleep Medicine

39755 Date St., Ste. 101
Murrieta, CA 92563
951 698-6629
www.completesleepsolutions.com

Pediatric Sleep Questionnaire

NAME_____ DATE_____

AGE_____ DOB_____ SEX M F RACE_____ HANDEDNESS; R L

HEIGHT _____ inches WEIGHT _____ lbs

NAME OF PARENT / ADULT GUARDIAN _____

RELATIONSHIP; mother father grandparent other_____

REFFERING PHYSICIAN_____

Please answer the following questions as completely as possible. Space at the end of the questionnaire is for any further questions/comments/observations you think important.
If a particular **question does not apply** to your child please **write NA**.
If the question applies, but **you do not know** the answer, please **write DK**

1. What is the main reason for this sleep disorders evaluation? (That is, what is the primary complaint?) _____
   _____
   _____
   _____
   _____
2. Do you consider this problem to be mild / moderate / severe
3. How long has this been a problem?_____months / years.
4. Has there been a sleep problem diagnosed in the past? yes no

   If yes, a)Where?_____

   b)What was the problem?_____
   _____

   c)What treatment(s) and did/do they help? _____
   _____
   _____
   _____

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MEDICATIONS

1. Please list the name and dose of any & all medications your child is currently taking. Please note how often each is taken and the reason the medication was prescribed. If you take no medications write NA.

NAME DOSE HOW OFTEN REASON

a)_____
b)_____
c)_____
d)_____
e)_____
f)_____

2. Caffeine use? yes no if yes average # daily servings_____
time of last caffeine intake _____AM / PM

3. Does your child have any allergies to medications? yes no
If yes, which ones: ._____
._____
._____

4. Does your child have any other allergies? yes no
List them: _____
._____
._____

MEDICAL & PSYCHOLOGICAL HISTORY

1. Does your child ever been diagnosed with:

High blood pressure	yes	no	Heart abnormality	yes	no
Asthma	yes	no	Diabetes	yes	no
Seizures	yes	no	Head trauma	yes	no
Kidney disease	yes	no	Meningitis	yes	no
Thyroid disease	yes	no	Intestinal abnormality	yes	no
Cerebral palsy	yes	no	Congenital defects	yes	no
Retarded development	yes	no	ADHD	yes	no
Panic/Anxiety	yes	no	Depression	yes	no

Other_____
Operations _____

If yes to any above, please explain_____
_____
_____

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SLEEP SCHEDULE / HYGIENE / ENVIRONMENT

1. What time does your child usually go to bed on weekdays? ____am/pm
2. What time is the bed room light turned off? ____pm
3. Who turns off the light? parent / child
4. What time does your child usually get up on weekdays? ____am/pm
5. What time does your child usually go to bed on weekends? ____am/pm
6. What time does your child usually get up on weekends? ____am/pm
7. What time is the bedroom light turned off? ____pm
8. Who turns off the light? parent / child
9. Do you keep this as a fairly regular sleep/wake schedule? yes no
10. Does your child
    - read/write in bed? yes no
    - play games in bed yes no
    - watch TV in bed? yes no
    - listen to music? yes no
    - eat in bed? yes no
    - have pet in room at night yes no
11. Does your child need a special object / toy to go to bed? yes no
12. Does your child need a bottle to go to sleep? yes no
13. As an infant did your child need any of the following devices to get to sleep?
    swing snuggly car ride being held rocking other_____
14. What type of bed is used now? crib single bed double bed other
15. Is the bedroom quiet, dark and a comfortable temperature? yes no
16. Does your child sleep alone? yes no
    If no, with whom? _____
17. On average, how long do you think it takes your child to fall asleep? _____ min / hrs
18. Does your child cry when put to bed? yes no
    if yes; do you let your child cry in bed in order to get to sleep? yes no
    If yes; how long do you let them cry? 10 / 20 / 30 min / as long as it takes
19. When unable to sleep, does your child get out of bed? yes no
    if yes; how long after initially going to bed _____min _____hrs
    if yes; what does your child do? _____
    _____
    how long are they up? _____min _____hrs

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20. What do you think prevents your child from falling asleep?
fears / loneliness / not sleepy / worries / household noises / other_____

21. Do you get annoyed/angry when your child does not sleep? yes no

22. Does your child nap during the day? yes no
If yes, in their own bed? yes no
how many naps a day?_____ per weekday _____ per weekend day
average length of a nap? _____minutes/hours

23. Does the child seem refreshed by naps? yes no

24. If you could set a schedule, what time would you put your child to bed?_____am/pm
and what time would you get them up? _____am/pm

EXCESSIVE DAYTIME SLEEPINESS

1. Is your child difficult to wake up in the morning? yes no

2. Does your child feel excessively tired or sleepy in the daytime? yes no

If yes, how long has this been occurring? _____months/years
has sleepiness effected your child's school performance yes no
has a teacher ever commented on this? yes no

3. Does this you feel that this tiredness / sleepiness is a result of poor sleep? yes no

4. Does your child fall asleep unintentionally while: (circle most accurate)

Reading	never	occasionally	frequently	always
Watching TV	never	occasionally	frequently	always
Conversation	never	occasionally	frequently	always
Meals	never	occasionally	frequently	always
School	never	occasionally	frequently	always

5. Has your child felt a sudden weakness or collapsed when laughing, angry or surprised? yes no

6. Has your child ever complained that they could not move just as they were falling asleep or waking up? yes no

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SLEEP BREATHING

1. Does your child snore? (circle one) never rarely occasionally frequently always
   Please circle "loudness" rating below:

   Your rating (none/minimal) **0 1 2 3 4 5 6 7 8 9 10** (very loud/disturbing)

2. With the snoring, do you see / hear any of the following:

Choking	yes	no
Episodes of stopping breathing	yes	no
Struggling to breath?	yes	no
Wheezing	yes	no
Awakenings	yes	no

3. Does position affect the snoring? yes no
   If yes, in which position is it the loudest? (circle one)
   back right left stomach other

4. What is your child's preferred sleeping position? back left right stomach other

MOVEMENT

1. Are your child's bed covers extremely messy when they wake up? yes no
2. Does your child awaken themselves by kicking legs during the night? yes no
3. Sibling in same bed complains of leg kicking during the night? yes no
4. Does your child complain of aching legs / need to move legs.? yes no
   If yes; is it worsened by inactivity such as lying or sitting? yes no
   does movement, walking or stretching relieve it? yes no
   is it worse in the evening or at bedtime? yes no
5. Does your child rock their body / head in bed before falling asleep? yes no

PARASOMNIAS

1. Does your child currently have nightmares? yes no
   If yes, how frequently? _____ & when did they begin? _____
   Did anything happen in their life that may have started the nightmares? yes no
   Explain: _____
   _____
2. Does your child wake from sleep feeling very scared without an obvious reason? yes no

   If yes, how frequently? _____
   How long does it last? _____
   Are these episodes associated with: sweating yes no
   rapid heart beat yes no

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Does your child scream and seem inconsolable? yes no

Does your child recall any dream or dream-fragments preceding an episode? yes no

If yes, describe:_____

Are they confused during these episodes? yes no

Do they remember these episodes in the morning? yes no

Does your child flail arms / kick legs, or have other violent movements with these episodes? yes no

Do they ever wet the bed during these episodes? yes no

3. Does your child grind or clinch their teeth at night? yes no

4. Does your child currently wet the bed? yes no
   if yes, for how many years?_____
   were they previously dry all night, then start wetting? yes no

5. Does your child currently sleepwalk? yes no in the past yes no
   if yes, how often?_____
   if yes, have they ever hurt themselves? yes no
   please explain _____
   _____

6. Does your child seem to act out dreams in their sleep? yes no

FAMILY SLEEP HISTORY

1. Do other members of your immediate family snore? yes no
2. Do any members of your immediate family have sleep apnea? yes no
   If yes, who:_____
3. Immediate family members with other sleep disorders? yes no
   If yes, who & what disorder_____
4. Have there been crib deaths (sudden infant death syndrome) in your family? yes no
   If yes, explain:_____

OPTIONAL

To better serve this community with information on sleep disorders and their treatments we would like to know how you heard about us: (Please Circle)

Doctor Phone book Newspaper Radio Television Friend or Family member
Other_____

Thank you for your cooperation filling out this questionnaire. Please be assured that this information is confidential.