New Patient Sleep Questionnaire

General Information

Patient Name_____

Reason for Visit_____

Pediatrician of Family Doctor_____

Birth History

How much did your child weigh at birth? _____ pounds _____ ounces

If your child was born early (premature), how many weeks? _____weeks

Was the child born vaginally or by C-section? □ Vaginally □ C-Section

Did the child require oxygen or a ventilator in the nursery? □ Oxygen □ Ventilation □ None

How old was the child at discharge from the hospital? _____(Age)

Medical History

Please list any hospitalizations. □ None
(Include your child's age at hospitalization and reason)

_____

_____

_____

Developmental History

Does your child have any issues with development? If so, please explain:

_____

_____

_____

Surgical History

Please list any operations. □ None
(Include your child's age at hospitalization and reason)

_____

_____

_____

Allergies

Please list all known allergies

Medications_____ Reaction_____

Medications_____ Reaction_____

Medications_____ Reaction_____

Foods_____ Reaction_____

Foods_____ Reaction_____

Other _____ Reaction_____

Current Medications

Please list all medications your child takes now.

Medication_____ Dose and frequency_____

Medication_____ Dose and frequency_____

Medication_____ Dose and frequency_____

Medication_____ Dose and frequency_____

Health Problems

Please list any health problems your child has. □ None

_____

_____

Immunizations

Are all immunizations up to date? □ Yes □ No

Family History

Please list ages of siblings and parents and describe any sleep problems, and chronic illnesses. (ex. asthma, diabetes, etc)

Mother Name_____ Age_____ Health information_____

Father Name_____ Age_____ Health information_____

Sibling name_____ Age_____ Health information_____

Sibling name_____ Age_____ Health information_____

Sibling name_____ Age_____ Health information_____

Are there any diseases or sleep disorders that run in your family? _____

_____

Sleep History

What concerns do you have about your child's sleep?

_____

_____

What have you tried to help with your child's sleep problems?

_____

_____

Please describe your child's bedtime routine:

_____

_____

Bedtime on weekdays_____ Weekends/Vacation_____

Wake time on weekdays_____ Weekends/Vacation_____

Does your child have his/her own room? ☐ Yes ☐ No

Does your child have his/her own bed? _____

Is a parent present when the child falls asleep? _____

Does your child take naps? _____

If so, what time? _____for how long? _____ how many days per week? _____

Does your child resist going to bed? _____

Does your child have difficulty falling asleep? _____

Does your child awaken at night? _____

If so what do you think awakens him/her? _____

If he/she awakens is there difficulty falling back asleep? _____

Is your child difficult to awaken in the morning? _____

Do you feel your child is a poor sleeper? _____

Please check any of the following that apply to your child.

□ None

□ Difficulty breathing when asleep
□ Stops breathing during sleep
□ Snores
□ Choking in sleep
□ Restless sleep
□ Sweating while sleeping
□ Daytime sleepiness
□ Poor appetite
□ Nightmares
□ Sleepwalking
□ Sleep talking
□ Screaming in sleep
□ Kicks legs in sleep
□ Grinding teeth in sleep
□ Bed wetting
□ Resists going to bed at bedtime
□ Gets out of bed at night
□ Trouble getting up in the morning
□ Falls asleep in school
□ Naps after school
□ Gasping/pausing in breathing during sleep
□ Uncomfortable or creepy crawly feeling in legs at night
□ Reports unable to move when falling asleep or upon awakening
□ Sees frightening visual images before falling asleep or upon awakening
□ Feels weak or loses control of muscles with strong emotions

Is there anything else you want us to know about your child?

Please describe any other concerns you want us to address, or things you think we should know, to protect your child during their clinic visit, operation, or hospitalization.

_____

_____

_____

Signature _____ Date _____