Santa Monica
SleepDisordersCenter
at St. John's Medical Plaza
Daniel Norman, M.D., Medical Director
Diplomate, American Board of Sleep Medicine

1301 Twentieth St., Suite 370
Santa Monica, CA 90404

Tel: (310) 828-2293
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PEDIATRIC SLEEP QUESTIONNAIRE

Date:_____

Child's Name: _____ DOB _____ Age:____ Ht:____ ft___in , Wt:____lbs,

My child's main sleep complaint is: _____Snoring _____Difficulty staying asleep ___ Excessive sleepiness ____Difficulty falling asleep

___Unwanted behaviors during the night (please explain):_____

_____

How severe is the problem? _____

Rate the severity of the problem: Mild > 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 < Severe

How long have he/she had this problem?_____

When does this problem occur?_____

Can you attribute the cause of this problem to anything? _____

Are there other symptoms associated with the problem?_____

What makes this problem worse or better? _____

Normal bedtime _____ Normal wake time_____
Weekend schedule:_____
Naps? (if so, when/how long): _____

Bedtime routine: _____

Routine mealtimes: _____

Check any of the behaviors that you have witnessed your child having during sleep.

	How long?
_____ Loud snoring	_____
_____ Gasping for breath	_____
_____ Snorting	_____
_____ Pauses in breathing	_____
_____ Night sweats	_____
_____ Turning blue	_____
_____ Restless sleep	_____
_____ Jumping out of bed, yelling, hitting	_____
_____ Sleep talking	_____
_____ Sleepwalking	_____
_____ Grinding teeth	_____
_____ Jerking of arms	_____

PLEASE CHECK ALL THAT APPLY TO YOUR CHILD:

_____ Apparent life threatening event during sleep
_____ Hypertension
_____ Snoring
_____ Observed pauses in breathing during sleep
_____ Vivid dreams
_____ Excessive weight gain within last year
_____ Awakens with headache
_____ Has a crawling sensation in his/her legs
_____ Does not feel tired at bedtime
_____ Light sleeper
_____ Dreams or has hallucinations while awake
_____ Difficulty staying awake even while trying
_____ Episodes of bedwetting
_____ Has trouble with memory
_____ Awakens with shortness of breath
_____ Awakens with chest pain
_____ Sudden sensation of weakness during emotional changes
_____ Unrefreshing naps
_____ Refreshing naps
_____ Wakes up with excessive sputum or coughing at night
_____ Paralysis upon awakening
_____ Behavioral problems at school/home
_____ Poor/deteriorating academic performance

Please explain any checked items above:

_____
_____
_____

PAST MEDICAL HISTORY
(CHECK ALL THAT APPLY)

_____ Measles
_____ Mumps
_____ Chicken Pox
_____ Hypertension
_____ Seizure disorder
_____ Head injury
_____ Kidney problems
_____ Thyroid problems
_____ Arthritis
_____ Reactive airways
_____ Muscular atrophy
_____ Diabetes
_____ Heart disease
_____ Sinus problems
_____ Respiratory problems
_____ Psychiatric problems
_____ Hypoglycemia
_____ Anemia
_____ Scoliosis
_____ Congenital malformations
_____ Other:_____
_____
_____
_____

FAMILY MEDICAL HISTORY

Please check all that apply to members of your family, and note the relationship in the space provided.

_____ Falling asleep during the day _____
_____ Excessively loud snoring _____
_____ Complaints of insomnia _____
_____ Restless or jerking of legs _____
_____ Emotional or psychiatric problems _____
_____ Seizure disorder _____
_____ Obesity _____
_____ Hypertension _____
_____ Narcolepsy _____
_____ Death in sleep _____
_____ Sudden infant Death Syndrome _____
_____ Heart problems _____
_____ Genetic or congenital defects _____

Please note any other concerns or questions you have regarding your child's sleep: _____
_____
_____
_____
_____
_____
_____

SURGERIES: Please list any surgeries that your child has had:
(including tonsillectomy, adenoidectomy, and/or tooth extraction for orthodontia):
Surgery: Date: Indication(s)
_____
_____
_____

MEDICATIONS:
Medication Dose Time(s)
_____
_____
_____
_____

Medication Allergies: _____

On a normal day, how many cups/glasses of caffeinated beverages does your child drink daily?
_____

Please indicate your name and relationship to patient: _____

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PATIENT'S NAME:_____ **D.O.B.** :_____

Epworth Sleepiness Scale

Date: _____

Please read these instructions carefully:

How likely are you to doze off or fall asleep in the situations described below, in contrast to feeling just tired?

This refers to your usual way of life in recent times. Even if you haven't done some of these things recently, try to work out how they would have affected you.

Use the following scale to choose the most appropriate number for each situation:

0 = would never doze
1 = Slight chance of dozing
2 = Moderate chance of dozing
3 = High chance of dozing

Situation	Chance of Dozing
1. Sitting and reading	_____
2. Watching TV	_____
3. Sitting, inactive in a public place (i.e., a theatre or a meeting)	_____
4. As a passenger in a car for an hour without a break	_____
5. Lying down to rest in the afternoon when circumstances permit	_____
6. Sitting and talking to someone	_____
7. Sitting quietly after a lunch without alcohol	_____
8. In a car, while stopped for a few minutes in traffic	_____
Total	_____