



Pediatric Sleep Evaluation Questionnaire

Child's Information	
Child's Name:	Child's Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female
Child's Birth date:	Child's Age:
Child's Social Security No.:	Today's Date:
Child's Primary Doctor:	Child's Referring Doctor:

Child's Problem or Area of Concern
What are your major concerns about your child's sleep? _____
What things have you done to help your child's problem?

Referral
Who asked that your child be seen by a sleep specialist?
<input type="checkbox"/> Pediatrician / Family Physician
<input type="checkbox"/> Child's parent or Guardian
<input type="checkbox"/> Surgical Specialist (e.g., ENT)
<input type="checkbox"/> Pediatric Specialist (e.g., allergist, neurologist, pulmonologist)
<input type="checkbox"/> Mental Health Worker (e.g., psychiatrist, psychologist, social worker)
<input type="checkbox"/> School teacher, nurse, counselor
<input type="checkbox"/> Child himself / herself
<input type="checkbox"/> Other: _____

Sleep History

Weekday Sleep Schedule

Write in the amount of time the child sleeps during a 24 hour period on weekdays. (add daytime and nighttime sleep) _____ hours _____ minutes

Child's usual bedtime on weekday nights: _____ :

Child's usual wake time on weekday mornings: _____ :

Weekend / Vacation Sleep Schedule

Write in the amount of time the child sleeps during a 24 hour period on weekends or vacation days. (add daytime and nighttime sleep) _____ hours _____ minutes

Child's usual bedtime on weekday nights: _____ :

Child's usual wake time on weekday mornings: _____ :

Nap Schedule

Number of days each week the child takes a nap: 1 2 3 4 5 6 7

If the child naps write in the usual nap time(s):

Nap #1 _____ : _____ a.m. p.m. To _____ : _____ a.m. p.m.

Nap #2 _____ : _____ a.m. p.m. To _____ : _____ a.m. p.m.

General Sleep

Does the child have a regular bedtime routine? Yes No

Does the child have his / her own bed? Yes No

Does the child have his / her own bedroom? Yes No

Is a parent / guardian present when the child falls asleep? Yes No

Does the child listen / watch radio / TV in bed? Yes No

Child usually falls asleep in:

- 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

Child sleep most of the night in:

- 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

Child usually wakes in the morning in:

- 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

Child is usually put in bed by: Mother Father Both parents Sibling Self Others

Write the amount of time the child spends in his / her bedroom before going to sleep: _____ Minutes

Child resists going to bed? Yes No IF yes, do you think this is a problem? Yes No

Child has difficulty falling asleep? Yes No IF yes, do you think this is a problem? Yes No

Child awakens during the night? Yes No IF yes, do you think this is a problem? Yes No

After a night time awakening, child has difficulty going back asleep? Yes No IF yes, do you think this is a problem? Yes No

Child is difficult to wake in the morning? Yes No IF yes, do you think this is a problem? Yes No

Child is a poor sleeper? Yes No IF yes, do you think this is a problem? Yes No

Current Sleep Symptoms							
(A) Never (does not happen)							
(B) Not Often (less than 1 night / day a week)							
(C) Sometimes (1 to 2 nights / days a week)							
(D) Often (3 to 5 nights / days a week)							
(E) Always (6 to 7 nights / days a week)							
(F) Do Not Know							
1	Stops breathing during sleep	A	B	C	D	E	F
2	Has difficulty breathing when asleep	A	B	C	D	E	F
3	Snores	A	B	C	D	E	F
4	Restless sleep	A	B	C	D	E	F
5	Sweating when sleeping	A	B	C	D	E	F
6	Daytime sleepiness	A	B	C	D	E	F
7	Poor Appetite	A	B	C	D	E	F
8	Has Nightmares	A	B	C	D	E	F
9	Sleep walks	A	B	C	D	E	F
10	Sleep talks	A	B	C	D	E	F
11	Screams out in his / her sleep	A	B	C	D	E	F
12	Kicks legs is sleep	A	B	C	D	E	F
13	Wakes up during the night	A	B	C	D	E	F
14	Gets out of bed at night	A	B	C	D	E	F
15	Trouble staying is his / her own bed	A	B	C	D	E	F
16	Resists going to bed at bedtime	A	B	C	D	E	F
17	Grinds his / her teeth	A	B	C	D	E	F
18	Uncomfortable feeling in legs; creepy-crawly feeling	A	B	C	D	E	F
19	Wets Bed	A	B	C	D	E	F

Current Daytime Symptoms							
(A) Never (does not happen)							
(B) Not Often (less than 1 night / day a week)							
(C) Sometimes (1 to 2 nights / days a week)							
(D) Often (3 to 5 nights / days a week)							
(E) Always (6 to 7 nights / days a week)							
(F) Do Not Know							
1	Has trouble getting up in the morning	A	B	C	D	E	F
2	Falls asleep at school	A	B	C	D	E	F
3	Naps after school	A	B	C	D	E	F
4	Has daytime sleepiness	A	B	C	D	E	F
5	Feels weak or loses muscles control with strong emotions	A	B	C	D	E	F
6	Reports unable to move when falling asleep or awakening	A	B	C	D	E	F
7	Sees frightening images when falling asleep or awakening	A	B	C	D	E	F

Medical and Psychiatric History

Past Medical History

Frequent Nasal congestion	<input type="checkbox"/> Yes	Age of diagnosis:
Trouble breathing through nose	<input type="checkbox"/> Yes	Age of diagnosis:
Sinus problems	<input type="checkbox"/> Yes	Age of diagnosis:
Chronic bronchitis or cough	<input type="checkbox"/> Yes	Age of diagnosis:
Allergies	<input type="checkbox"/> Yes	Age of diagnosis:
Asthma	<input type="checkbox"/> Yes	Age of diagnosis:
Frequent Colds or Flu	<input type="checkbox"/> Yes	Age of diagnosis:
Frequent ear infections	<input type="checkbox"/> Yes	Age of diagnosis:
Frequent Strep throat infections	<input type="checkbox"/> Yes	Age of diagnosis:
Difficulty swallowing	<input type="checkbox"/> Yes	Age of diagnosis:
Acid reflux (gastroesophageal reflux)	<input type="checkbox"/> Yes	Age of diagnosis:
Poor or delayed growth	<input type="checkbox"/> Yes	Age of diagnosis:
Excessive weight	<input type="checkbox"/> Yes	Age of diagnosis:
Hearing problems	<input type="checkbox"/> Yes	Age of diagnosis:
Speech problems	<input type="checkbox"/> Yes	Age of diagnosis:
Vision problems	<input type="checkbox"/> Yes	Age of diagnosis:
Seizures / Epilepsy	<input type="checkbox"/> Yes	Age of diagnosis:
Morning headaches	<input type="checkbox"/> Yes	Age of diagnosis:
Cerebral palsy	<input type="checkbox"/> Yes	Age of diagnosis:
Heart disease	<input type="checkbox"/> Yes	Age of diagnosis:
High blood pressure	<input type="checkbox"/> Yes	Age of diagnosis:
Sickle cell disease	<input type="checkbox"/> Yes	Age of diagnosis:
Genetic disease	<input type="checkbox"/> Yes	Age of diagnosis:
Chromosome problem (e.g., Down's)	<input type="checkbox"/> Yes	Age of diagnosis:
Skeleton problem (e.g., dwarfism)	<input type="checkbox"/> Yes	Age of diagnosis:
Cranofacial disorder (e.g., Pierre-Robin)	<input type="checkbox"/> Yes	Age of diagnosis:
Thyroid problems	<input type="checkbox"/> Yes	Age of diagnosis:
Eczema (e.g., itchy skin)	<input type="checkbox"/> Yes	Age of diagnosis:
Pain	<input type="checkbox"/> Yes	Age of diagnosis:
Head / brain injury	<input type="checkbox"/> Yes	Age of diagnosis:
Meningitis	<input type="checkbox"/> Yes	Age of diagnosis:

Past Psychiatric / Psychological History

Autism	<input type="checkbox"/> Yes	Age of diagnosis:
Developmental Delay	<input type="checkbox"/> Yes	Age of diagnosis:
Hyperactivity / ADHD	<input type="checkbox"/> Yes	Age of diagnosis:
Anxiety / Panic attacks	<input type="checkbox"/> Yes	Age of diagnosis:
Obsessive Compulsive disorder	<input type="checkbox"/> Yes	Age of diagnosis:
Depression	<input type="checkbox"/> Yes	Age of diagnosis:
Suicide	<input type="checkbox"/> Yes	Age of diagnosis:
Learning disability	<input type="checkbox"/> Yes	Age of diagnosis:
Drug use / abuse	<input type="checkbox"/> Yes	Age of diagnosis:
Behavioral disorder	<input type="checkbox"/> Yes	Age of diagnosis:
Psychiatric admission	<input type="checkbox"/> Yes	Age of diagnosis:

Please list any additional psychological, psychiatric, emotional, or behavioral problems diagnosed or suspected by a physician or psychologist. _____

Current Medical History

Please list any medications child is currently taking:

Medication	Dose	How Often
1		
2		
3		
4		
5		

Long-Term Medical Problems

If the child has long-term medical problems, please list the three you think are the most important.

- 1
- 2
- 3

Surgeries / HospitalizationsHas the child had his / her tonsils removed? Yes Age of surgery: _____Has the child has his her adenoids removed? Yes Age of surgery: _____Has the child ever had ear tubes? Yes Age of surgery: _____

Please list any additional hospitalizations or surgeries:

- 1 _____ Age: _____
- 2 _____ Age: _____
- 3 _____ Age: _____

Health HabitsDoes the child drink caffeinated beverages? (e.g., Coke No Yes Amount per day: _____
Pepsi, Mountian Dew, Orange Soda, Tea, coffee) Time of last drink: _____**School Preformance (if school age)**

Child's grade: _____

Has child ever repeated a grade? No YesIs child enrolled in any special education classes? No Yes

How many schol days has child missed this year? _____

How many school days did child miss last year? _____

How many school days has child been late this year? _____

How many school days was child late last year? _____

Child's grades this year: Excellent Good Average Poor FailingChild's grades last year: Excellent Good Average Poor Failing

Family Information

Pregnancy / Delivery

Pregnancy Normal Difficult

Delivery Term Pre-term Post-term

Child's Birth Weight:

Only child? Yes No If No, circle birth order: 1st 2nd 3rd 4th 5th 6th

Mother	Father
Age: _____	Age: _____
Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Single <input type="checkbox"/> Widowed <input type="checkbox"/> Separated <input type="checkbox"/> Remarried	Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Single <input type="checkbox"/> Widowed <input type="checkbox"/> Separated <input type="checkbox"/> Remarried
Education: _____	Education: _____
Work: <input type="checkbox"/> Unemployed <input type="checkbox"/> Part-time <input type="checkbox"/> Full-time	Work: <input type="checkbox"/> Unemployed <input type="checkbox"/> Part-time <input type="checkbox"/> Full-time
Occupation: _____	Occupation: _____

Persons Living In Home

Name:	Relationship	Age:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Family Sleep History

Does anyone in the child's family have a sleep disorder? No Yes

If Yes, mark the disorders and relationship.

Insomnia	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Brother / sister	<input type="checkbox"/> Grandparent
Snoring	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Brother / sister	<input type="checkbox"/> Grandparent
Sleep Apnea	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Brother / sister	<input type="checkbox"/> Grandparent
Restless Legs Syndrome	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Brother / sister	<input type="checkbox"/> Grandparent
Periodic Limb Movement Disorder	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Brother / sister	<input type="checkbox"/> Grandparent
Sleep walking / sleep terrors	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Brother / sister	<input type="checkbox"/> Grandparent
Sleep talking	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Brother / sister	<input type="checkbox"/> Grandparent
Narcolepsy	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Brother / sister	<input type="checkbox"/> Grandparent
Other: _____	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Brother / sister	<input type="checkbox"/> Grandparent

Is there any other information you think would be helpful for the Physician to know? _____

Reviewed in Detail with Patient and Parent/Guardian

Vincent J. Gimino, MD

Date