Pediatric Sleep Questionnaire (Age < 16 years old)

Patient Name_____Date of Birth_____

Doctor _____ Date Completed_____

Reason for visit_____

Referring Doctor_____

Please mark if you experience any of the following symptoms:

___ Snoring

___ Stop breathing during sleep

___Daytime sleepiness

___Morning headache

___Dry mouth

___Sleepwalking

___If yes, injury to self or others while sleepwalking

___Sleeptalking

___Complex behaviors during sleep (sleepeating, etc)

___Grinding of teeth

___Bedwetting during sleep

___Restless legs syndrome (creepy crawly feelings of the legs/arms that occur at night and with inactivity. Relieved by moving legs)

___Vivid, dream-like images that occur while falling asleep or waking up

___Inability to move body after waking up (Sleep paralysis)

___Episodes of muscular weakness that are triggered by emotion (i.e. laughing, crying, stress)

___Acting out dreams violently. If yes, have you ever injured yourself? _____

___Previously diagnosed with sleep apnea by sleep study testing

PLEASE COMPLETE OTHER SIDE

Sleep Schedule

Bedtime: _____ am/pm(weekdays) and _____ am/pm (weekends)

Wake time:_____ am/pm (weekdays) and _____ am/pm (weekends)

How long does it take for you to fall asleep? _____

Number of times you wake up per night _____

How long does it take you to fall back to sleep?_____

Total amount of sleep per day (excluding naps)_____

Amount of time you nap per day_____

Do you have a bedtime routine?_____

Please indicate if you have any of the following symptoms/conditions:

___Tiredness/Fatigue

___Bruising of the skin

___Sinus problems

___Behavioral problems

___Neck pain

___Shortness of breath

___Cough

___Home oxygen use

___Asthma

___Cardiac disease

___Swelling of the legs and/or body

___Heart disease

___Liver disease

___Kidney Disease

___Back pain

___Declining school grades

___ Use of electronics before bedtime

___Anxiety

___Depression

___Stroke

___Seizures

___Diabetes

___Thyroid problems

___Low iron (anemia)

___CPAP/BiPAP use

___Acid reflux

Please list any medications for sleep that you have tried_____

Please list date(s) and location(s) of previous sleep study testing_____

Please list the names of any doctors you would like to have today's note sent to_____