dell children's
medical center of central texas
A member of the Seton Family of Hospitals

Specialty Care Center
SLEEP PROGRAM
Patient Questionnaire

SLEEP EVALUATION QUESTIONNAIRE

Directions:
Please answer each of the following questions by writing in or choosing the best answer. This will help us better understand your child's problems, interpret the sleep study, and provide treatment recommendations.

CHILD'S INFORMATION	
Child's name:	Child's gender:
Child's birth date:	Child's age:
Child's racial/ethnic background:	
What are your major concerns about your child's sleep?	
What things have you tried to help your child's problems?	

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Sleep Program

Child's Name: _____ Date of Birth: _____/_____/_____

SLEEP HISTORY

WEEKDAY SLEEP SCHEDULE

Write in the amount of time child sleeps during a 24-hour period on weekdays
(add daytime and nighttime sleep): _____ hours _____minutes
The child's usual bedtime on weekday nights: _____:_____
The child's usual waketime on weekday mornings: _____:_____

WEEKEND/VACATION SLEEP SCHEDULE

Write in the amount of time child sleeps during a 24-hour period during weekends and vacations
(add daytime and nighttime sleep): _____hours _____minutes
The child's usual bedtime on weekend/vacation nights: _____:_____
The child's usual waketime on weekend/vacation mornings: _____:_____

NAP SCHEDULE

Number of days each week child takes a nap: ☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7

If child naps, write in 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 bedroom? ☐ Yes ☐ No
Does the child have his/her own bed? ☐ Yes ☐ No
Is a parent present when your child falls asleep? ☐ Yes ☐ No

Child usually falls asleep in:	Child sleeps most of the night in:	Child usually wakes in the morning in:
☐ Own room in own bed (alone)	☐ Own room in own bed (alone)	☐ Own room in own bed (alone)
☐ Parents' room in own bed	☐ Parents' room in own bed	☐ Parents' room in own bed
☐ Parents' room in parents' bed	☐ Parents' room in parents' bed	☐ Parents' room in parents' bed
☐ Sibling's room in own bed	☐ Sibling's room in own bed	☐ Sibling's room in own bed
☐ Sibling's room in sibling's bed	☐ Sibling's room in sibling's bed	☐ Sibling's room in sibling's bed

Child is usually put to bed by: ☐ Mother ☐Father ☐ Both Parents ☐Self ☐ Other

Write in 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 difficult 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 nighttime awakening, child has difficulty falling back asleep?	☐Yes ☐ No	**If yes,** do you think this is a problem?	☐Yes ☐ No
Child is difficult to awaken 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

Child's Name: _____ Date of Birth: _____/_____/_____

CURRENT SLEEP SYMPTOMS			
	Yes	**No**	**Specific Concern**
Difficulty breathing when asleep			
Stops breathing during sleep			
Snores			
Restless sleep			
Sweating when sleeping			
Daytime sleepiness			
Poor appetite			
Nightmares			
Sleepwalking			
Sleep talking			
Screaming in his/her sleep			
Kicks legs in sleep			
Wakes up at night			
Gets out of bed at night			
Trouble staying in his/her bed			
Resists going to bed at bedtime			
Grinds his/her teeth			
Uncomfortable feeling in his/her legs; creepy-crawly feelings			
Wets bed			
CURRENT DAYTIME SYMPTOMS			
	Yes	**No**	**Specific Concern**
Trouble getting up in the morning			
Falls asleep in school			
Naps after school			
Daytime Sleepiness			
Feels weak or loses control of his/her muscles with strong emotions			
Reports unable to move when falling asleep or waking			
Sees frightening visual images before falling asleep or upon waking			
Growing/leg pains			

Child's Name: _____ Date of Birth: _____/_____/_____

MEDICAL HISTORY								
PREGNANCY/DELIVERY								
Pregnancy	☐ Normal	☐ Difficult						
Delivery	☐ Term	☐ Pre-term _____wks	☐ Post-term _____wks					
Child's birth weight:	_____lbs	_____oz						
Only child?	☐ Yes	☐ No	If no, circle birth order:	1st	2nd	3rd	4th	5th	6th	7th
PAST MEDICAL HISTORY								
Frequent nasal congestion	☐ Yes	Age at Diagnosis:						
Trouble breathing through his/her nose	☐ Yes	Age at Diagnosis:						
Sinus problems	☐ Yes	Age at Diagnosis:						
Chronic Bronchitis or cough	☐ Yes	Age at Diagnosis:						
Allergies	☐ Yes	Age at Diagnosis:						
Asthma	☐ Yes	Age at Diagnosis:						
Frequent colds or flu's	☐ Yes	Age at Diagnosis:						
Frequent ear infections	☐ Yes	Age at Diagnosis:						
Difficulty swallowing	☐ Yes	Age at Diagnosis:						
Acid reflux (gastro esophageal reflux)	☐ Yes	Age at Diagnosis:						
Poor or delayed growth	☐ Yes	Age at Diagnosis:						
Excessive weight	☐ Yes	Age at Diagnosis:						
Hearing problems	☐ Yes	Age at Diagnosis:						
Speech problems	☐ Yes	Age at Diagnosis:						
Vision problems	☐ Yes	Age at Diagnosis:						
Seizures/Epilepsy	☐ Yes	Age at Diagnosis:						
Morning headaches	☐ Yes	Age at Diagnosis:						
Cerebral Palsy	☐ Yes	Age at Diagnosis:						
Heart disease	☐ Yes	Age at Diagnosis:						
High blood pressure	☐ Yes	Age at Diagnosis:						
Sickle Cell Disease	☐ Yes	Age at Diagnosis:						
Genetic disease	☐ Yes	Age at Diagnosis:						
Chromosome problem (e.g. Down's)	☐ Yes	Age at Diagnosis:						
Skeleton problem (e.g. dwarfism)	☐ Yes	Age at Diagnosis:						
Craniofacial disorder (e.g. Pierre-Robin)	☐ Yes	Age at Diagnosis:						
Thyroid problems	☐ Yes	Age at Diagnosis:						
Eczema (itchy skin)	☐ Yes	Age at Diagnosis:						

Child's Name: _____ Date of Birth: _____/_____/_____

PAST PSYCHIATRIC/PHYCHOLOGICAL HISTORY		
Autism	☐ Yes	Age at Diagnosis:
Developmental delay	☐ Yes	Age at Diagnosis:
Hyperactivity/ADHD	☐ Yes	Age at Diagnosis:
Anxiety/Panic Attacks	☐ Yes	Age at Diagnosis:
Obsessive Compulsive Disorder	☐ Yes	Age at Diagnosis:
Depression	☐ Yes	Age at Diagnosis:
Suicide	☐ Yes	Age at Diagnosis:
Learning disability	☐ Yes	Age at Diagnosis:
Drug use/abuse	☐ Yes	Age at Diagnosis:
Behavioral disorder	☐ Yes	Age at Diagnosis:
Psychiatric Admission	☐ Yes	Age at Diagnosis:

Please list any additional psychological, psychiatric, emotional, or behavioral problems diagnosed or suspected by a physician/psychologist.
1.
2.
3.

CURRENT MEDICAL HISTORY		
Please list any medication your child currently takes:		
Medicine	Dose	How Often?
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		

LONG-TERM MEDICAL PROBLEMS
1.
2.
3.
4.
5.
6.
7.
8.

Child's Name: _____ Date of Birth: _____/_____/_____

SURGERIES/HOPITILIZATIONS			
Has your child ever had his/her tonsils removed?	☐ No	☐ Yes	Age at surgery: _____
Has your child ever had his/her adenoids removed?	☐ No	☐ Yes	Age at surgery: _____
Has your child ever had ear tubes?	☐ No	☐ Yes	Age at surgery: _____
Please list any additional hospitalizations or surgeries:			

HEALTH HABITS			
Does your child drink caffeinated beverages? (e.g., Coke, Pepsi, Mountain Dew, Iced Tea)	☐No	☐Yes	Amount per day:_____

SCHOOL PERFORMANCE

CURRENT SCHOOL PERFORMANCE (if school-aged)					
Your child's grade:					
Has your child ever repeated a grade?	☐ Yes	☐ No			
Is your child enrolled in any special education classes?	☐ Yes	☐ No			
How many school days has your child missed so far this year?					
How many school days did your child miss last year?					
How many school days was your child late this year?					
How many school days was your child late last year?					
Child's grades this year:	☐ Excellent	☐ Good	☐ Average	☐ Poor	☐Failing
Child's grades last year:	☐ Excellent	☐ Good	☐ Average	☐ Poor	☐Failing

Child's Name: _____ Date of Birth: _____/_____/_____

FAMILY'S INFORMATION	
MOTHER	**FATHER**
Age:	Age:
Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Remarried	Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Remarried
Education:	Education:
Work:	Work:
Occupation:	Occupation:

PERSONS LIVING IN HOME		
Name	Relationship	Age

FAMILY SLEEP HISTORY				
Does anyone in the family have a sleep disorder? ☐ Yes ☐ No **If yes,** mark the disorder(s):				
Insomnia	☐Mother	☐Father	☐ Brother/Sister	☐Grandparent
Snoring	☐Mother	☐Father	☐ Brother/Sister	☐Grandparent
Sleep Apnea	☐Mother	☐Father	☐ Brother/Sister	☐Grandparent
Restless Leg Syndrome	☐Mother	☐Father	☐ Brother/Sister	☐Grandparent
Periodic Limb Movement Disorder	☐Mother	☐Father	☐ Brother/Sister	☐Grandparent
Sleepwalking/sleep terrors	☐Mother	☐Father	☐ Brother/Sister	☐Grandparent
Sleep talking	☐Mother	☐Father	☐ Brother/Sister	☐Grandparent
Narcolepsy	☐Mother	☐Father	☐ Brother/Sister	☐Grandparent
Bed-wetting	☐Mother	☐Father	☐ Brother/Sister	☐Grandparent
Thyroid disturbance	☐Mother	☐Father	☐ Brother/Sister	☐Grandparent
High blood pressure	☐Mother	☐Father	☐ Brother/Sister	☐Grandparent
Diabetes	☐Mother	☐Father	☐ Brother/Sister	☐Grandparent
Anxiety disorder	☐Mother	☐Father	☐ Brother/Sister	☐Grandparent
Depression	☐Mother	☐Father	☐ Brother/Sister	☐Grandparent
Other psychiatric disturbances	☐Mother	☐Father	☐ Brother/Sister	☐Grandparent
Obesity	☐Mother	☐Father	☐ Brother/Sister	☐Grandparent
Other:	☐Mother	☐Father	☐ Brother/Sister	☐Grandparent

Child's Name: _____ Date of Birth: _____/_____/_____

REFERRAL
Who asked that your child be seen by a sleep specialist? □ Pediatrician/Family Physician □ Child's parent or guardian □ Pediatric specialist (e.g., Allergist, Neurologist, Pulmonologist) □ Mental health specialist (e.g., psychiatrics, Psychologist, Social Worker) □ School teacher, nurse, counselor □ Child himself/herself □ Other:_____

QUESTIONNAIRE INFO		
Questionnaire filled out by	Relationship to patient	Date