unmhealth.org/services/sleep-medicine/ | 505.272.6110 | 1101 Medical Arts Ave. NE , Building 2 | Albuquerque, NM 87102

Pediatric Sleep History

Patient Name: _____ ***Preferred Name:*** _____

Date of Birth: _____ ***Date of Appointment:*** _____ ***Date this form completed:*** _____

Address: _____

Home Phone: _____ **Cell Phone:** _____ **Other Phone:** _____

Referring Provider Name and Address: _____

Primary Care Provider Name and Address: _____

Person Completing this form: _____ ***Relationship to patient:*** _____

Has your child had a sleep study before? ☐ ***YES*** ☐ ***No***

If so, ***where*** *and* ***when?*** _____

Does your child have or use at night:

☐*Oxygen- Liters per minute: ___*

☐*24/7?* ☐CPAP

☐*Night use only?* ☐BiPAP

Prescriber: _____ **Durable Medical Company (DME):** _____

PLEASE ANSWER THESE QUESTIONS TO HELP US UNDERSTAND YOUR CHILD'S SLEEP

What are your concerns about your child's sleep? _____

_____

At what age did sleep problems begin? _____

Describe how the problem has changed over time: _____

_____

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

_____

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SLEEP HISTORY

Bedtimes on typical WEEKDAYS or SCHOOL DAYS:

My child's bed time is _____ □ pm □ am
It takes my child _____ □ min □ hours to fall asleep
My child's wake up time is _____ □ pm □ am
My child wakes with an alarm □
My child wakes up on their own □

Bedtimes on typical WEEKENDS or DAYS OFF:

My child's bed time is _____ □ pm □ am
It takes my child ____ □ min □ hours to fall asleep
My child's wake up time is _____ □ pm □ am
My child wakes with an alarm □
My child wakes up on their own □

Does your child awaken during the night? □ YES □ NO If YES, how many times? _____
If awakening at night, does the child have trouble returning to sleep? □ YES □ NO
Is your child difficult to awaken in the morning? □ YES □ NO
Is your child too sleepy during the day? □ YES □ NO
Do your child take naps during the day? □ YES □ NO
If YES, how many naps per day? ____ How long are the naps? _____ minutes ____hours

BEDROOM ENVIRONMENT

CHECK WHICH OF THE FOLLOWING APPLY TO YOUR CHILD:

□ Sleeps alone
□ Sleeps with parent(s)
□ Child falls asleep your bed
□ Child shares bedroom with someone else (If YES: Whom?_____)

□ Child comes to your bed at night
□ Pet(s) sleep with the child
□ Television in bedroom
□ Computer/laptop/tablet in bedroom
□ Cellphone or smart phone in bedroom
□ Video game player in bedroom

BEDTIME HABITS

Does your child have a bedtime routine? □ YES □ NO If YES, mark which activities apply:

□ Favorite toy nearby to fall asleep
□ Watches TV or video to fall asleep
□ Plays on laptop or tablet
□ Needs to be fed to fall asleep
□ Needs to be rocked to sleep
□ Plays video games
□ Listens to music
□ Read a story

□ Bath or shower
□ Prayer
□ Needs someone else in the room
□ Can only fall asleep in your bed
□ Texts or talks on smart phone
□ Other (please describe)
_____

CHECK THE BOX TO ANSWER 'YES' OR 'NO' FOR EACH QUESTION:

Does your child drink any beverages containing caffeine? □ YES □ NO
If yes, what and how often (coffee, tea, caffeinated soda) _____
What does your child do for physical activity or exercise? _____
Does your child drink or eat within 2 hours of bedtime? □ YES □ NO If YES, what _____?
Does your child get up to eat in the middle of the night? □ YES □ NO

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WHICH OF THE FOLLOWING DOES YOUR CHILD HAVE (CHECK THE BOX IF YES)

□ Snoring
□ Wakes from sleep gasping for breath or choking
□ Stops breathing during sleep
□ Sweats excessively when sleeping
□ Gasps or snorts when sleeping
□ Grinds teeth when sleeping
□ Wakes up with a dry mouth or sore throat
□ Struggles or works to breathe during sleep
□ Cannot sleep on his/her back
□ Strange sleeping positions
□ Difficulty falling asleep due to nasal stuffiness
□ Shortness of breath or coughing that is worse at night
□ Difficulty falling asleep due to pain
□ Prefers to sleep with parents
□ Refuses to go to bed
□ Frequently makes excuses to get out of bed at night
□ Problems learning because too sleepy
□ Fears about sleeping, bedroom, or the dark
□ Restless sleep
□ Grinds teeth while sleeping
□ Cannot keep legs still when trying to fall asleep
□ Wets bed while sleeping
□ Frequent nightmares
□ Wakes up confused and disoriented
□ Sleep talking
□ Sleep walking
□ Acts out dreams
□ Wakes up with stomach pain or acid taste
□ Frequent headache when awakens
□ Trouble falling asleep due to depression, anxiety, worry
□ Has seizures while sleeping
□ Growing pains
□ Claustrophobia
□ Anger or hyperactive outbursts due to sleepiness
□ Legs give out when laughing or emotional
□ Falls asleep without warning or in odd places

RATE HOW SLEEPY YOUR CHILD OR ADOLESCENT FEELS DURING THE DAY

These questions ask how likely you child is to DOZE OFF or FEEL SLEEPY (not just feeling tired or fatigued) in the following situations.
This refers to how sleepy your child felt **within the last 2 WEEKS**. If your child has not been in any or these situations recently, try to IMAGINE how sleepy you feel your child would feel in these situations. Use the following scale to mark and "X" next to the most appropriate number in each situation:

0 = My child would NEVER doze off
1 = My child would have a SMALL CHANCE of dozing off (about 10% of the time)
2 = My child would have a MEDIUM CHANCE of dozing off (about half of the time)
3 = My child would have a HIGH CHANCE of dozing off (almost every time)

Chance of Dozing - Please check one box in each row bellow:

□0 □1 □2 □3 Sitting and reading
□0 □1 □2 □3 Sitting and watching TV or video
□0 □1 □2 □3 Sitting in classroom at school during the morning
□0 □1 □2 □3 Sitting and riding in a car or bus for about a half hour
□0 □1 □2 □3 Lying down to rest or nap in the afternoon
□0 □1 □2 □3 Sitting and talking to someone
□0 □1 □2 □3 Sitting quietly by yourself after lunch
□0 □1 □2 □3 Sitting and eating a meal

Place Sticker Here

FAMILY SLEEP HISTORY

Does your child have any BLOOD RELATIVES who have or had (check all that apply):

	Father	Mother	Brother	Sister	Maternal Grandfather	Maternal Grandmother	Paternal Grandfather	Paternal Grandmother	Children	None
ADHD or ADD										
Excessive sleepiness										
Insomnia										
Narcolepsy										
Restless Legs Syndrome (RLS)										
Sleep apnea										
Sleep walking/night terrors										
Snoring										
Sudden infant death										

BIRTH HISTORY

My child was born □ Full term □ Premature Birth weight? _____ lbs _____ oz Was the pregnancy, labor, or birth complicated? IF YES, please describe: _____

DEVELOPMENTAL AND ACADEMIC HISTORY

At what age did your child? Walk? _____ years _____ months Talk? _____ years _____ months

How were your child's grades LAST YEAR? □ Excellent □ Good □ Average □ Poor

Does your child have BEHAVIOR PROBLEMS? □ YES □ NO

Has your child been LATE TO SCHOOL because of difficulty awakening in the morning? □ YES □ NO

Have your child's TEACHER(S) reported any of the following?

□ Too sleepy
□ Outbursts of anger
□ Sad/Blue mood
□ Falls asleep/naps in class
□ Daydreams
□ Disruptive in class
□ Grades are falling
□ Aggressive behavior
□ Short attention span
□ Stares into space
□ Does not follow instructions
□ Outbursts of hyperactivity
□ Other: _____

SOCIAL HISTORY

Who lives with the child? _____
Are there any smokers at home? □ YES □ NO
Is there anyone in the home who has a problem with drugs or alcohol? □ YES □ NO
Does the family have any pets? □ YES □ NO
How many hours of tv does your child watch a day? _____hrs
How many hours of tv does your child watch in a week? _____hrs
How many hours of video games does your child play a day? _____hrs
How many hours of video games does your child play in a week? _____hrs
How many hours does your child spend on the computer or tablet a day? _____hrs
How many hours does your child spend on the computer or tablet in a week? _____hrs
How many hours does your child spend on the cell phone or smart phone in a day _____hrs
How many hours does your child spend on the cell phone or smart phone in a week? _____hrs

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PAST MEDICAL HISTORY

Does your child have now or in the past any of the following. Check all that apply.

□ Acid reflux (GERD)
□ ADHD or ADD
□ Adenoids removed
□ Anxiety
□ Asthma
□ Bedwetting
□ Behavior problems
□ Born premature
□ Brain injury □ Cancer
□ Chronic pain
□ Cystic Fibrosis
□ Depression
□ Developmental delay
□ Diabetes
□ Ear tubes
□ Environmental allergies
□ Fainting
□ Febrile seizure
□ Frequent ear infections
□ Headaches
□ Hearing problems
□ Heart murmur
□ Heart problems
□ Heart surgery
□ Head injury
□ High blood pressure
□ High cholesterol
□ Injury to nose
□ Kidney problems
□ Needs/Has glasses
□ Overweight
□ Pneumonia
□ Problems at birth
□ Poor appetite
□ Picky eater
□ Seasonal allergies
□ Seizure disorder
□ Sinus problems
□ Slow growth
□ Speech problems
□ Thyroid problems
□ Tonsillectomy
□ Underweight
□ Uses oxygen

Please list or describe ANY OTHER MEDICAL PROBLEMS not mentioned above: _____

_____

_____

_____

Does your child have ALLERGIES? If yes, to what? _____

Does your child have a: □ Latex allergy □ Tape allergy □ Food allergies

Other allergies or sensitivities (please describe): _____

What medications does your child take (times and dosages if you know it): _____

_____

_____

_____

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REVIEW OF SYSTEMS

Please check all that apply in the last two weeks to your child):

EYES	**PULMONARY**	***NEUROLOGICAL***
□ Trouble seeing	□ Wheezing	□ Headaches
□ Needs glasses	□ Shortness of breath	□ Dizziness
□ Eye irritation or discomfort	□ Nighttime cough	□ Fainting
EARS, NOSE, THROAT	***GASTROINTESTINAL***	□ Tics
□ Ear pain	□ Acid reflux / heartburn	□ Staring spells
□ Nosebleeds	□ Nausea / vomiting	***MUSCULOSKELETAL***
□ Stuffy or congested nose	□ Frequent stomachaches	□ Back or joint pain
□ Difficulty swallowing	***GENITOURINARY***	□ Clumsy walking
□ Sore throat	□ Urinary tract infections	□ Growing pains
□ Sinus problems	***HEMATOLOGIC / IMMUNOLOGIC***	□ Poor coordination
□ Nasal speech	□ Abnormal bleeding	***CARDIOVASCULAR***
CONSTITUTIONAL	□ Easy bruising	□ Chest pain
□ Fever	□ Infections	□ Tightness / pressure in chest
□ Chills	***PSYCHOLOGICAL***	□ Skipped heart beats
□ Sweating during sleep	□ Aggressive / Angry a lot	□ Poor circulation
□ Underweight	□ Anxiety or Panic attacks	
□ Overweight	□ Cries easily	
SKIN	□ Sad or blue mood / depression	
□ Rash	□ Difficulty completing tasks	
□ Skin sores or lesions	□ Easily distracted	
□ Eczema	□ Easily frustrated	
□ Itching	□ Can't sit still	

Place Sticker Here

Family History (please mark an "x" next any of the below that **blood relatives have or had)**

	Father	Mother	Brother	Sister	Maternal Grandfather	Maternal Grandmother	Paternal Grandfather	Paternal Grandmother	Children	None
Alzheimer's										
Arthritis										
Asthma										
Autoimmune Disease										
Birth Defects										
Blood Disorder (like anemia or blood cancer)										
Clotting Disorder (blood clots or bleeding)										
Developmental Disability (like autism or dyslexia)										
Diabetes										
Environmental-Seasonal Allergies/Eczema										
Excessive Alcohol or Drug Use										
Gallbladder Disease										
GI Disease										
Glaucoma (too much pressure in the eyes)										
Gout (a kind of arthritis)										
Headaches										
Heart Disease										
Hepatitis										
High Cholesterol										
HIV/AIDS										
High Blood Pressure										
Immune Deficiency										
Liver Disease										
Lung Disease										
Mental Illness (like depression or anxiety)										
Muscular/Skeletal (bone) Disorders										
Pancreas Disease										
Renal Disease										
Seizures										
Stroke										
TB (tuberculosis)										
Thyroid Disease										
Breast Cancer										
Colon Cancer										
Ovarian Cancer										
Prostate Cancer										
Skin Cancer										
Uterine or Cervical Cancer										
All negative (none)										
History Unknown										

Thank you for completing this questionnaire.

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