# 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 birthdate: | Child's age: |
| Child's racial/ethnic background: ☐ White/ Caucasian ☐ Black/African-American ☐ Asian-American ☐ Native-American ☐ Hispanic-Latino ☐ Multi-racial ☐ Other | |
| | |
| What are your major concerns about your child's sleep? | |
| What things have you tried to help your child's problem? | |
| | |

| 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 ☐ Others

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

| General Sleep Continued | | | |
|---|---|---|---|
| Child resists going to bed? | ☐ yes<br>☐ no | **If yes**, do you think this is a problem? | ☐ yes<br>☐ no |
| Child has difficulty falling asleep? | ☐ yes<br>☐ no | **If yes**, do you think this is a problem? | ☐ yes<br>☐ no |
| Child awakens during the night? | ☐ yes<br>☐ no | **If yes**, do you think this is a problem? | ☐ yes<br>☐ no |
| After nighttime awakening, child has difficulty falling back to sleep? | ☐ yes<br>☐ no | **If yes**, do you think this is a problem? | ☐ yes<br>☐ no |
| Child is difficult to awaken in the morning? | ☐ yes<br>☐ no | **If yes**, do you think this is a problem? | ☐ yes<br>☐ no |
| Child is a poor sleeper? | ☐ yes<br>☐ no | **If yes**, do you think this is a problem? | ☐ yes<br>☐ no |

| Current Sleep Symptoms | | Yes | No | Specific Concern |
|---|---|---|---|---|
| 1. | Difficulty breathing when asleep | | | |
| 2. | Stops breathing during sleep | | | |
| 3. | Snores | | | |
| 4. | Restless sleep | | | |
| 5. | Sweating when sleeping | | | |
| 6. | Daytime sleepiness | | | |
| 7. | Poor appetite | | | |
| 8. | Nightmares | | | |
| 9. | Sleepwalking | | | |
| 10. | Sleep talking | | | |
| 11. | Screaming in his/her sleep | | | |
| 12. | Kicks legs in sleep | | | |
| 13. | Wakes up at night | | | |
| 14. | Gets out of bed at night | | | |
| 15. | Trouble staying in his/her bed | | | |
| 16. | Resists going to bed at bedtime | | | |
| 17. | Grinds his/her teeth | | | |
| 18. | Uncomfortable feeling in his/her legs; creepy-crawly feeling | | | |
| 19. | Wets bed | | | |

| Current Daytime Symptoms | | | | |
|---|---|---|---|---|
| | | **Yes** | **No** | **Specific Concern** |
| 1. | Trouble getting up in the morning | | | |
| 2. | Falls asleep in school | | | |
| 3. | Naps after school | | | |
| 4. | Daytime sleepiness | | | |
| 5. | Feels weak or loses control of his/her muscles with strong emotions | | | |
| 6. | Reports unable to move when falling asleep or upon waking | | | |
| 7. | Sees frightening visual images before falling asleep or upon waking | | | |
| 8. | Growing / leg pains | | | |

| 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 |

| MEDICAL AND PSYCHIATRIC HISTORY | | |
|---|---|---|
| **PAST MEDICAL HISTORY** | | |
| Frequent nasal congestion | ☐ Yes | Age of diagnosis: |
| Trouble breathing through his/her nose | ☐ Yes | Age of diagnosis: |
| Sinus problems | ☐ Yes | Age of diagnosis: |
| Chronic bronchitis or cough | ☐ Yes | Age of diagnosis: |
| Allergies | ☐ Yes | Age of diagnosis:<br>Allergic to what: |
| Asthma | ☐ Yes | Age of diagnosis: |
| Frequent colds or flu's | ☐ Yes | Age of diagnosis: |
| Frequent ear infections | ☐ Yes | Age of diagnosis: |
| Frequent strep throat infections | ☐ Yes | Age of diagnosis: |
| Difficulty swallowing | ☐ Yes | Age of diagnosis: |
| Acid reflux (gastro esophageal reflux) | ☐ Yes | Age of diagnosis: |
| Poor or delayed growth | ☐ Yes | Age of diagnosis: |
| Excessive weight | ☐ Yes | Age of diagnosis: |
| Hearing problems | ☐ Yes | Age of diagnosis: |
| Speech problems | ☐ Yes | Age of diagnosis: |
| Vision problems | ☐ Yes | Age of diagnosis: |
| Seizures/Epilepsy | ☐ Yes | Age of diagnosis: |
| Morning headaches | ☐ Yes | Age of diagnosis: |
| Cerebral palsy | ☐ Yes | Age of diagnosis: |
| Heart disease | ☐ Yes | Age of diagnosis: |
| High blood pressure | ☐ Yes | Age of diagnosis: |
| Sickle cell disease | ☐ Yes | Age of diagnosis: |
| Genetic disease | ☐ Yes | Age of diagnosis: |
| Chromosome problem (e.g., Down's) | ☐ Yes | Age of diagnosis: |
| Skeleton problem (e.g., dwarfism) | ☐ Yes | Age of diagnosis: |
| Craniofacial disorder (e.g., Pierre-Robin) | ☐ Yes | Age of diagnosis: |
| Thyroid problems | ☐ Yes | Age of diagnosis: |
| Eczema (itchy skin) | ☐ Yes | Age of diagnosis: |
| Pain | ☐ Yes | Age of diagnosis: |

| PAST PSYCHIATRIC/PSYCHOLOGICAL HISTORY | | |
|---|---|---|
| Autism | ☐ Yes | Age of diagnosis: |
| Developmental delay | ☐ Yes | Age of diagnosis: |
| Hyperactivity/ADHD | ☐ Yes | Age of diagnosis: |
| Anxiety/Panic Attacks | ☐ Yes | Age of diagnosis: |
| Obsessive Compulsive Disorder | ☐ Yes | Age of diagnosis: |
| Depression | ☐ Yes | Age of diagnosis: |
| Suicide | ☐ Yes | Age of diagnosis: |
| Learning disability | ☐ Yes | Age of diagnosis: |
| Drug use/abuse | ☐ Yes | Age of diagnosis: |
| Behavioral disorder | ☐ Yes | Age of diagnosis: |
| Psychiatric Admission | ☐ Yes | Age of 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 medications 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. |

| SURGERIES/HOSPITALIZATIONS | | | | |
|---|---|---|---|---|
| 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?<br>(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? | ☐ No | ☐ Yes | | | |
| Is your child enrolled in any special education classes? | ☐ No | ☐ Yes | | | |
| 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 so far 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 |

## FAMILY'S INFORMATION

| MOTHER | | | | FATHER | | | |
|---|---|---|---|---|---|---|---|
| Age: | | | | Age: | | | |
| Marital Status: | ☐ Single<br>☐ Married | ☐ Divorced<br>☐ Widowed | ☐ Separated<br>☐ Remarried | Marital Status: | ☐ Single<br>☐ Married | ☐ Divorced<br>☐ Widowed | ☐ Separated<br>☐ Remarried |
| Education: | | | | Education | | | |
| Work: | ☐ Unemployed | ☐ Part-time | ☐ Full-time | Work: | ☐ Unemployed | ☐ Part-time | ☐ Full-time |
| 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 legs 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 |

| FAMILY SLEEP HISTORY CONTINUED | | | | |
|---|---|---|---|---|
| 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 |

## REFERRAL

Who asked that your child be seen by a sleep specialist?

- ☐ Pediatrician/Family physician
- ☐ Child's parent or guardian
- ☐ Surgical specialist (e.g., ENT)
- ☐ Pediatric specialist (e.g., allergist, neurologist, pulmonologist)
- ☐ Mental health specialist (e.g. psychiatrist, psychologist, social worker)
- ☐ School teacher, nurse, counselor
- ☐ Child himself/ herself
- ☐ Other: ____________________

## QUESTIONNAIRE INFO

| Date questionnaire filled out: | Questionnaire filled out by: | Relationship to patient: |
|---|---|---|
| | | |