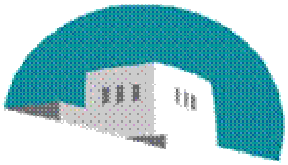
Pediatric Sleep History



UNM HOSPITALS
SLEEP DISORDERS CENTER
The *EXPERTS* IN SLEEP MEDICINE

1101 Medical Arts Ave NE Bldg 2, Albuquerque, NM 87102 Phone: 505-272-6110 Fax: 505-272-6112 http://hospitals.unm.edu/SDC

Patient Name: _____ ***Date of appointment:*** _____
Address: _____
Phone numbers: ***Home (____)*** _____ ***Cell (____)*** _____ ***Work (____)*** _____ ***Other (____)*** _____
Form completed by: _____ ***Date completed:*** _____

Referring Doctor Name and Address _____
_____

Primary Care Doctor Name and Address _____
_____

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? _____
Please describe how the problem has changed over time: _____
_____

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

On typical WEEKDAYS or SCHOOL DAYS:
My child's bed time is _____ □ *pm* □ *am*.
It takes him/her _____ □ *min* □ *hours* to fall asleep.
My child's wake up time is _____ □ *pm* □ *am*.
Is your child difficult to awaken? □ YES □ NO

On typical WEEKENDS or DAYS OFF:
My child's bed time is _____ □ *pm* □ *am*.
It takes him/her _____ □ *min* □ *hours* to fall asleep.
My child's wake up time is _____ □ *pm* □ *am*.
Is your child difficult to awaken? □ YES □ NO

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

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

□ Favorite toy nearby to fall asleep
□ Needs to be fed to fall asleep
□ Needs to be rocked to sleep
□ Needs someone else in the room
□ Can only fall asleep in your bed
□ Watches TV or video to fall asleep
□ Plays on computer
□ Plays video games
□ Listen to music
□ Read a story
□ Bath or shower
□ Prayer
□ Other (please describe) _____

How long does your child's bedtime routine usually take? _____ □ *min* □ *hours*
Who usually puts your child to bed? □ Mother □ Father □ Both parents □ Self
□ Other: _____

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

□ YES □ NO ***Does your child share a bedroom with someone else?***
If YES: Whom? _____

□ YES □ NO ***Does your child have his/her own bed?***

What kind of bed does your child have: □ Crib □ Twin □ Full □ Queen □ King
□ Bunk bed □ Water bed □ Your bed □ Other: _____

Where does your child usually fall asleep? □ Own bed □ Parent's bed □ Sibling's bed
□ Other: _____

Where does your child sleep most of the night? □ Own bed □ Parent's bed □ Sibling's bed
□ Other: _____

Where does your child usually wake up? □ Own bed □ Parent's bed □ Sibling's bed
□ Other: _____

□ YES □ NO ***Do pets sleep on your child's bed?***

□ YES □ NO ***Is there a TV or computer in your child's bedroom?***

□ YES □ NO ***Does your child read or listen to music in bed?***

□ YES □ NO ***Does your child feel safe in his/her bedroom?***

□ YES □ NO ***Do you enforce regular bedtimes for your child?***

How long does your child usually spend in his or her bedroom before going to sleep?
_____ □ *min* □ *hours*

□ YES □ NO ***Does your child have difficulty falling asleep at night***

If YES: Why do you think your child has difficulty falling asleep? _____
_____

□ YES □ NO ***Does your child wake up during the night?***
If YES: How many times does he or she USUALLY wake up? _____
How long does your child USUALLY stay awake? _____ □ *min* □ *hours*
What wakes your child up? _____

□ YES □ NO ***Does your child have difficulty falling back to sleep after awakening?***

□ YES □ NO ***Is your child too sleepy during the day?***
If YES: Please describe WHY you think your child is too sleepy during the day _____
_____

□ YES □ NO ***Does your child take naps during the day?***
If YES: How many naps does your child USUALLY take per day? _____
How long is the USUAL nap? _____ □ *min* □ *hours*
Does your child wake up from the nap feeling rested? □ YES □ NO
Where does your child nap? □ His/her bed □ Your bed □ Crib □ Car □ School bus
□ Living room/couch □ In school
□ Other: _____

Does your child have any of the following symptoms? If YES, please check the box:

□ Snoring
□ Wakes up gasping for breath or choking
□ Stops breathing during sleep

□ Struggles to breathe during sleep
□ Restless sleep
□ Sweats excessively while asleep

□ Wets the bed while asleep
□ Cannot sleep on his/her back
□ Strange sleeping positions

□ Grinds teeth while asleep
□ "Acts out" dreams
□ Frequent nightmares

□ Frequent sleepwalking
□ Frequent talking in his/her sleep
□ Falls asleep in odd situations or places

□ Cannot keep his/her legs still prior to falling asleep
□ Has an irresistible need to move his/her legs when lying down or sitting
□ Wakes up with heartburn or a sour, stomach-acid taste (acid reflux or indigestion)

□ Wakes up with a sore throat
□ Wakes up with heart beating fast or missing beats
□ Wakes up confused and disoriented

□ Often has a headache when he/she wakes up
□ Often wakes up with nausea or wanting to vomit, or vomits
□ Often has a dry mouth when he/she wakes up.

□ Shortness of breath or coughing that is worse at night
□ Large tonsils
□ Difficulty falling asleep due to nasal congestion

□ 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 with friendships or social interactions because of sleepiness
□ Problems with learning because of sleepiness

□ Problems with concentration and attention because of sleepiness
□ Fears about sleeping, bedroom, or the dark
□ Difficulty falling asleep due to sadness or depression

□ Difficulty falling asleep due to being worried or anxious
□ Often has sudden weakness (not dizziness) in the knees, neck, or arms when he/she is startled, laughing, angry, or emotional

□ Suddenly falls asleep without warning
□ “Growing pains”
□ Anger or hyperactive outbursts that may be related to sleepiness

□ Has seizures while sleeping
□ Claustrophobia
□ Weight gain

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

□ YES □ NO ***Does your child have regular meal times?***
What time does your child usually eat *Breakfast* _____ □ *am* □ *pm*
Lunch _____ □ *am* □ *pm*
Dinner _____ □ *am* □ *pm*
Snacks _____ □ *am* □ *pm*

□ YES □ NO ***Does your child DRINK or EAT within 2 hours of bedtime?***
If YES, how many ounces does your child drink? _____ *ounces of* _____
What does he or she eat? _____

□ YES □ NO ***Does your child get up to eat in the middle of the night?***

□ YES □ NO ***Does your child drink any beverages containing CAFFEINE?***
If YES: Please give more details about HOW MUCH and HOW OFTEN.
Coffee: _____
Hot Tea: _____
Iced Tea: _____
Caffeinated soda (including Mountain Dew, Dr. Pepper, Coke, Pepsi, diet soda, and energy drinks): ___
_____

How many hours of TV does your child watch in a DAY? _____*hrs* **in a WEEK?** _____*hrs*

How many hours of VIDEO GAMES does your child play in a DAY? _____*hrs* **in a WEEK?** _____*hrs*

How many hours does your child spend on the COMPUTER in a DAY? _____*hrs* **in a WEEK?** _____*hrs*

What does your child do for PHYSICAL ACTIVITY or EXERCISE? _____

_____

_____

RATE HOW SLEEPY YOUR CHILD FEELS DURING THE DAY

How likely is your child to DOZE OFF or FEEL SLEEPY (not just feeling tired or fatigued) in the following situations? This refers to how sleepy he or she has been RECENTLY (such as in the last TWO WEEKS). If your child has not been in these situations recently, try to IMAGINE how sleepy he or she would feel in these situations.

Use the following scale to choose (CIRCLE) the most appropriate number in each situation:

0 = My child would NEVER doze off
1 = My child would have a SLIGHT CHANCE of dozing off
2 = My child would have a MODERATE CHANCE of dozing off
3 = My child would have a HIGH CHANCE of dozing off

Chance of Dozing

0	1	2	3	In school
0	1	2	3	After school
0	1	2	3	Sitting quietly in a public place (such as in a movie, classroom, or church)
0	1	2	3	As a passenger in a car
0	1	2	3	Lying down to rest in the afternoon
0	1	2	3	Playing quietly with friends
0	1	2	3	Sitting quietly after a lunch
0	1	2	3	Watching TV

At what age did your child: *Walk?* ____ □ years □ months *Talk?* ____ □ years □ months

Does your child:

□ Point to body parts □ Know his or her age □ Add / Subtract
□ Say the alphabet □ Count (how high? ____) □ Multiply / Divide
□ Know his or her colors □ Write his or her name □ Read at grade level

□ YES □ NO ***Is your child in school?*** If YES: What grade? _____

□ YES □ NO ***Has he or she ever been HELD BACK a grade?***

□ YES □ NO ***Is he or she in SPECIAL EDUCATION classes?***

□ YES □ NO ***Does he or she have a LEARNING DISABILITY?***

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 □ Outbursts of hyperactivity
□ Short attention span □ Stares into space □ Does not follow instructions
□ Other: _____

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

□ YES □ NO ***Does your child have BEHAVIOR PROBLEMS?***
If YES: Please describe
_____
_____

□ YES □ NO ***Has your child been LATE TO SCHOOL because of difficulty awakening in the morning?***
If YES: How many times this year? _____ How many times last year? _____

□ YES □ NO ***Do you give your child any medicines or herbs (prescribed or over-the-counter) to HELP him or her GO TO SLEEP?*** If YES: Please list the name, dose, and frequency_____
_____
_____

□ YES □ NO ***Do you give your child any medicines or herbs (prescribed or over-the-counter) to HELP him or her STAY AWAKE?*** If YES: Please list the name, dose, and frequency _____
_____
_____

Please list any MEDICATIONS your child CANNOT TAKE because of allergy or side effects:

_____

□ YES □ NO ***Does your child have allergies to LATEX?***

Does your child have: □ Food Allergies □ Seasonal Allergies □ Environmental Allergies

Please list ALL the medications (including over-the-counter and nutritional supplements) that your child is CURRENTLY taking:

Name	Dose	Frequency	Name	Dose	Frequency

□ YES □ NO ***Are your child's IMMUNIZATIONS up to date?***

Does your child HAVE NOW or HAD IN THE PAST any of the following? Check all that apply:

□ Acid reflux (GERD)
□ ADD or ADHD
□ Adenoids removed
□ ALTE or near-SIDS
□ Anemia
□ Anxiety
□ Asthma
□ Bedwetting
□ Behavior problems
□ Born premature
□ Brain injury
□ Cancer
□ Chronic pain
□ Cystic Fibrosis
□ Depression
□ Developmental delay
□ Diabetes
□ Ear tubes
□ Environmental allergies
□ Fainting
□ Febrile convulsions
□ Frequent ear infections
□ Headaches
□ Hearing problems
□ Heart murmur
□ Heart problems
□ Heart surgery
□ Head injury
□ High blood pressure
□ High cholesterol
□ HIV and/or AIDS
□ Injury to nose
□ Kidney problems
□ Mental illness
□ Needs/Has glasses
□ Overweight or Obesity
□ Pneumonia
□ Problems at birth
□ Poor appetite or picky eater
□ Seasonal allergies
□ Seizures or seizure disorder
□ Sinus problems
□ Slow growth
□ Speech problems
□ Thyroid problems
□ Tonsillectomy

Please list ANY OTHER MEDICAL PROBLEMS not mentioned above:

_____

_____

Please list any OPERATIONS or HOSPITALIZATIONS your child has had:

Approximate Date	Type of surgery or Reason for hospitalization
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Was your child born □ Full term □ Premature **What was your child's birth weight?** ____ lbs ____ oz

Was the pregnancy, labor, or birth complicated? IF YES, please describe: _____

_____

_____

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

□ ADD / ADHD
□ Alzheimer's Disease
□ Allergies
□ Anemia
□ Anxiety
□ Asthma
□ Bipolar disorder
□ Brain tumor
□ Cancer or Leukemia
□ Learning problems
□ Depression
□ Diabetes
□ Headaches / Migraines
□ Hyperactivity
□ Emphysema / COPD
□ Epilepsy / Seizures
□ Excessive sleepiness
□ Heart disease
□ High blood pressure
□ High cholesterol
□ Insomnia
□ Kidney disease
□ Loud snoring
□ Mental illness
□ Narcolepsy
□ Obesity
□ Migraine headaches
□ Restless Legs Syndrome
□ Schizophrenia
□ SIDS or Crib Death
□ Sleep apnea
□ Sleep problems
□ Sleepwalking
□ Snoring
□ Stroke / Brain Hemorrhage
□ Thyroid disease
□ Tuberculosis

Please list any other significant MEDICAL CONDITIONS that RUN IN THE FAMILY:

_____

_____

□ YES □ NO ***Does your child have siblings?***

If YES: List the name, age, and sex of the siblings

NAME_____ AGE_____ SEX_____ NAME_____ AGE_____ SEX_____

NAME_____ AGE_____ SEX_____ NAME_____ AGE_____ SEX_____

NAME_____ AGE_____ SEX_____ NAME_____ AGE_____ SEX_____

Who else lives at home with your child?

NAME_____ RELATIONSHIP _____

NAME_____ RELATIONSHIP _____

NAME_____ RELATIONSHIP _____

NAME_____ RELATIONSHIP _____

NAME_____ RELATIONSHIP _____

NAME_____ RELATIONSHIP _____

□ YES □ NO Are there any smokers in the home?

□ YES □ NO Are there any guns in the 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?

Please check any symptoms that have bothered your child in the LAST TWO WEEKS.

In the LAST TWO WEEKS my child has had:

Eyes

□ Trouble seeing

□ Needs glasses

□ Eye irritation or discomfort

Ears, Nose, Throat

□ Ear pain

□ Nosebleeds

□ Stuffy or congested nose

□ Difficulty swallowing

□ Sore throat

□ Sinus problems

□ Nasal speech

Neck

□ Neck stiffness or pain

□ Swollen neck glands

Cardiovascular

□ Chest pain

□ Tightness / pressure in chest

□ Skipped heart beats

□ Poor circulation

Musculoskeletal

□ Back or joint pain

□ Clumsy walking

□ Growing pains

□ Poor coordination

Pulmonary

□ Wheezing

□ Shortness of breath

□ Nighttime cough

Gastrointestinal

□ Acid reflux / heartburn

□ Nausea / vomiting

□ Frequent stomach aches

Genitourinary

□ Urinary tract infections

Hematologic / Immunologic

□ Abnormal bleeding

□ Easy bruising

□ Infections

Skin

□ Rash

□ Skin sores or lesions

□ Eczema

Neurologic

□ Headaches

□ Dizziness

□ Fainting

□ Tics

□ Staring spells

Constitutional

□ Underweight

□ Overweight

Psychological

□ Aggressive / Angry a lot

□ Anxiety or Panic attacks

□ Cries easily

□ Sad or blue mood / depression

□ Fidgity

□ Difficulty completing tasks

□ Easily distracted

□ Easily frustrated

□ Doesn't play like other kids

□ Poor eye contact

□ Physical or emotional abuse

Thank you for completing this questionnaire.