



THE SLEEP INSTITUTE OF UTAH

"Professional Sleep Solutions"

Pediatric Patient Questionnaire

South Ogden Sleep Center * 1464 East Ridgeline Drive Suite 104 * South Ogden, UT 84405
Phone: (801) 475-5848 * Fax: (801) 475-5853

Child's Information	
Name:	Date of Birth:
Gender: Male / Female	Age:
Address:	Parents Name(s):
Social Security #	Phone: (H) _____ (W) _____ (C) _____

Insurance Information	
Insurance Company :	Policy Number:
Name of Insured:	Group Number:
Relation:	
Family MD:	Phone Number:
Referring MD:	Phone Number:

May we contact your child's physician for further information? Yes _____ No _____

It is important for you to be as accurate as possible in answering the following questions. The purpose of this questionnaire is to get a total picture of your child's background and the nature of your child's present problem. Please complete these questions as thoroughly as you can.

In your own words describe your major concern(s) about your child's sleep, including when and how this began and what treatment your child has received in the past:

Child's Sleep History	
Does your child have a regular bedtime? Yes / No	Is the parent in the room when the child falls asleep at home? Yes / No
Does the child have their own room? Yes / No	Does your child drink caffeinated beverages? Yes / No

Past Medical History

Please circle any Current or Past Medical Problems that your child incurred (if any) and note date diagnosed.	
	Date
Frequent nasal congestion	
Trouble breathing through his/her nose	
Sinus problems	
Chronic bronchitis or cough	
Allergies	
Asthma	
Frequent colds or flu	
Frequent ear infections	
Frequent strep throat infections	
Difficulty swallowing	
Acid reflux (gastro esophageal reflux)	
Poor or delayed growth	
Excessive weight	
Hearing problems	
Speech problems	
Vision problems	
Seizures/Epilepsy	
Morning headaches	
Cerebral palsy	
Heart disease	
High blood pressure	
Sickle cell disease	
Genetic disease	
Chromosome problem (e.g., Down's syndrome)	
Skeleton problem (e.g., dwarfism)	
Craniofacial disorder (e.g., Pierre-Robin)	
Thyroid problems	
Eczema (itchy skin)	
Pain	
Attention Deficit Disorder (ADD)	

PAST PSYCHIATRIC/PSYCHOLOGICAL HISTORY

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Current Medications

Please list any medications and dose your child is currently taking:	
1.	
2.	
3.	
4.	
5.	

Family Sleep History

Does any family member have a sleep disorder?	Yes / No
If Yes Relation	
Please circle the sleep disorder:	
Insomnia	Snoring
Sleep Apnea	Restless Legs Syndrome
Periodic Limb Movement Disorder	Sleepwalking / Sleep Terrors
Sleep Talking	Narcolepsy
Other:	

Sleep Schedule

Weekday:

During a 24 hour period what is the amount of time your child sleep's on weekdays: _____ hrs. _____ minutes

The child's usual bedtime on weekday nights : _____ : _____

The child's usual wake time on weekday mornings: _____ : _____

Weekend:

During a 24 hour period what is the amount of time your child sleep's on weekends: _____ hrs. _____ minutes

The child's usual bedtime on weekend nights : _____ : _____

The child's usual wake time on weekend mornings: _____ : _____

Naps:

How many naps does your child take during the day: 1 / 2 / 3 / 4 / 5 / 6 / 7 / 8 / 9 / 10

What is your child usual nap time:

_____ : _____ am / pm TO _____ : _____ am / pm

_____ : _____ am / pm TO _____ : _____ am / pm

_____ : _____ am / pm TO _____ : _____ am / pm

Child Sleep Symptoms

Please circle the appropriate number:

1 = Never

4 = 3 – 4 nights per week

7 = 6 – 7 nights per week

2 = 1 – 2 nights per week

5 = 4 – 5 nights per week

3 = 2 – 3 nights per week

6 = 5 – 6 nights per week

Difficulty breathing when asleep	1	2	3	4	5	6	7
Stops breathing during sleep	1	2	3	4	5	6	7
Snores	1	2	3	4	5	6	7
Restless Sleep	1	2	3	4	5	6	7
Sweating when sleeping	1	2	3	4	5	6	7
Daytime sleepiness	1	2	3	4	5	6	7
Poor Appetite	1	2	3	4	5	6	7
Nightmares	1	2	3	4	5	6	7
Sleepwalking	1	2	3	4	5	6	7
Sleep Talking	1	2	3	4	5	6	7
Screaming in his/her sleep	1	2	3	4	5	6	7
Kicks legs in sleep	1	2	3	4	5	6	7
Wakes up at night	1	2	3	4	5	6	7
Gets out of bed at night	1	2	3	4	5	6	7
Trouble staying in his/her bed	1	2	3	4	5	6	7
Resists going to bed at bedtime	1	2	3	4	5	6	7
Grinds his/her teeth	1	2	3	4	5	6	7
Uncomfortable feeling in his/her legs; creepy-crawling feeling	1	2	3	4	5	6	7
Wets bed	1	2	3	4	5	6	7

Child's Daytime Symptoms

Trouble getting up in the morning	1	2	3	4	5	6	7
Falls asleep at school	1	2	3	4	5	6	7
Naps after school	1	2	3	4	5	6	7
Daytime Sleepiness	1	2	3	4	5	6	7
Feels weak or loses control of his/her muscles with strong emotions	1	2	3	4	5	6	7
Reports unable to move when falling asleep or upon waking	1	2	3	4	5	6	7
Sees frightening visual images before falling asleep or upon waking	1	2	3	4	5	6	7