QUINCY MEDICAL GROUP
Sleep Center

Pediatric Clinical Sleep Disorders Questionnaire

Name:_____ Age: _____ DOB: _____ Sex: _____

Height_____ft._____inches Weight_____lbs.

Address:_____
(city) (state) (zip)

Home Phone(_____)_____ Parent/Guardian Name _____

Referring Physician_____ Phone Number (_____)_____

Family Physician_____ Phone Number (_____)_____

Please answer the following questions as if you are describing a typical night or sleep pattern. This information is confidential so please answer as completely as possible.

What is the main concern regarding sleep? (Why did the provider order a sleep study?)

_____

_____

_____

When did sleep problems begin? (month and year)_____

Has the patient had a prior sleep study? ❑YES ❑NO

If yes, where was the study performed?_____

When was the study performed?_____

What were the results?_____

Please attach previous sleep study results

Does the patient wear CPAP/BiPAP? ❑YES ❑NO

If yes, what pressure and mask?_____

Does the patient sleep in his/her own bed? ❑YES ❑NO

Does the patient suffer from seasonal or environmental allergies? ❑YES ❑NO

Patient Name_____ **Date** _____

The patient usually sleeps for _____ hours every night.

During the **week** the patient usually:
Goes to bed at _____p.m./a.m. *(time)*
Gets up at_____p.m./a.m. *(time)*
Sleeps a total of _____hours

During the **weekend** I usually:
Goes to bed at _____p.m./a.m. *(time)*
Gets up at_____p.m./a.m. *(time)*
Sleeps a total of _____hours

The patient naps daily: ❑ YES ❑ NO *If yes, nap time is:* _____

It usually takes the patient _____hours_____minutes to fall asleep.

The patient usually wakes up _____ times during the night.

Please explain what wakes the patient:_____
_____

The patient has difficulty going back to sleep: ❑ Always ❑ Frequently ❑ Occasionally ❑ Never

Does the patient snore? ❑Always ❑Frequently ❑Occasionally ❑ Never *Age when snoring started:*_____

Snoring in all positions: ❑ YES ❑ NO *Position in which snoring is worse:* _____

Snoring is described as: ❑ Light ❑ Moderate ❑ Loud ❑ Very Loud

Are there problems with nasal breathing: ❑ YES ❑ NO
*If yes, please describe:*_____

Does the patient wake in the night gasping for air, wheezing, or complaining of shortness of breath?	❑ Always	❑ Frequently	❑ Occasionally	❑ Never
Does the patient toss & turn a great amount:	❑ Always	❑ Frequently	❑ Occasionally	❑ Never
Does the patient have mood or behavior problems?	❑ Always	❑ Frequently	❑ Occasionally	❑ Never
Are there problems with attention/ADHD?	❑ Always	❑ Frequently	❑ Occasionally	❑ Never
Does the patient grind their teeth during sleep?	❑ Always	❑ Frequently	❑ Occasionally	❑ Never
Does the patient walk, talk, or scream during sleep?	❑ Always	❑ Frequently	❑ Occasionally	❑ Never
Is the patient bedtime resistant?	❑ Always	❑ Frequently	❑ Occasionally	❑ Never
Does the patient usually have difficulty falling asleep?	❑ Always	❑ Frequently	❑ Occasionally	❑ Never

Does the patient have epilepsy or has the patient ever had a seizure? ❑ Yes ❑ No Date of last seizure _____

Has the patient had his/her tonsils and/or adenoids removed? ❑ Yes ❑ No Date _____

Patient Name_____ **Date** _____

Does the patient have nightmares or night terrors? ❑ Always ❑ Frequently ❑ Occasionally ❑ Never

Bed wetting? ❑ Always ❑ Frequently ❑ Occasionally ❑ Never

After a typical night's sleep, does the patient *seem*: ❑Refreshed ❑Fairly Rested ❑Tired ❑Very Drowsy

Does the patient have trouble staying awake: ❑During a car ride ❑Watching TV ❑During school

Does the patient fight sleep during the day?

❑ Always ❑ Frequently ❑ Occasionally ❑ Never *This last occurred when?*_____

This primarily occurs (circle all that applies): ❑ Mornings ❑ Afternoons ❑ Evenings

After sleep, the patient appears or ***reports feeling***:

❑Refreshed ❑ Fairly Rested ❑ Somewhat Tired ❑ Very Drowsy

Drowsiness is greatest in the: ❑ Morning ❑ Afternoon ❑ Evening

Is there a history in the patient's family of sleep apnea? ❑ YES ❑ NO

Does the patient stop breathing during sleep? ❑ Always ❑ Frequently ❑ Occasionally ❑ Never

Does the patient complain of headaches in the morning? ❑ Always ❑ Frequently ❑ Occasionally ❑ Never

Does the patient drink caffeinated beverages? ❑YES ❑NO

If yes, please circle beverage and indicate amount per day.

Coffee _____ Tea _____ Soda _____ Other _____

For patients under the age of 18, a parent or guardian is required to remain with the patient for the duration of the study.

Name of parent or guardian to stay with child: _____

Patient Name______________________________________ **Date** ______________________