Banner Health

PEDIATRIC SLEEP QUESTIONNAIRE

PATIENT INFORMATION

Gender: Male Female Date of Test: _____

Name:_____ Age/Sex:_____ Date of Birth: _____

Referring Physician:_____ Height: _____ inches Weight: _____ lbs.

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

What things have you tried to help your child's sleep issues?

SLEEP HISTORY

Usual Sleep Schedule		
Number of hours your child sleeps during a 24-hour period including day and nighttime sleep	**_____ hours**	
Your child's usual bedtime	**Weekdays _____ pm/am**	**Weekends _____ pm/am**
Your child's usual wake time	**Weekdays _____ am/pm**	**Weekends _____ am/pm**
Number of days each week your child naps	**_____ days**	

Usual nap times	Nap 1: _____	Nap 2: _____	Nap 3: _____

General Sleep

Does your child have a regular bed time routine?	Yes	No
Does your child have their own bedroom?	Yes	No
Does your child have their own bed?	Yes	No
Is a parent present when your child falls asleep?	Yes	No
Is there a television, computer or radio in your child's room?	Yes	No

Child usually falls asleep...	Child sleeps most the night in...	Child usually wakes in the morning...
☐ 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
☐ Other:	☐ Other:	☐ Other:

Child is usually put to bed by: ☐ Mother ☐ Father ☐ Sibling ☐ Self ☐ Other

Does your child...

Resist going to bed?	If yes, how long has this been a problem?	____ years ____ months
Have difficulty falling asleep?	If yes, how long has this been a problem?	____ years ____ months
Awaken during the night?	If yes, how long has this been a problem?	____ years ____ months
After a nightmare, have difficulty falling back to sleep?	If yes, how long has this been a problem?	____ years ____ months
Have difficulty awakening in the morning?	If yes, how long has this been a problem?	____ years ____ months
Is your child a poor sleeper?	If yes, how long has this been a problem?	____ years ____ months

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Current Sleep Symptoms	Frequency of Occurrence					
	Never	Rarely	Occasionally	Regularly	Frequently	Don't Know
Difficulty breathing when asleep						
Stops breathing during sleep						
Snores						
Restless sleep						
Sweating when sleeping						
Daytime sleepiness						
Poor appetite						
Nightmares						
Sleepwalking						
Sleep talking						
Screaming in their sleep						
Kicks legs during sleep						
Wakes up at night						
Gets out of bed at night						
Trouble staying in their bed at night						
Resists going to bed at bedtime						
Grinds their teeth						
Uncomfortable feeling in their legs: creepy-crawly						
Wets bed						

Current Daytime Symptoms	Frequency of Occurrence					
	Never	Rarely	Occasionally	Regularly	Frequently	Don't Know
Trouble getting up in the morning						
Falls asleep in school						
Naps after school						
Daytime sleepiness						
Feels weak or loses control of their muscles with strong emotions (laughter/fear)						
Reports being unable to move when falling asleep or waking up						
Reports seeing strange or frightening images before falling asleep or waking up						

Family Sleep History				
Insomnia	☐ Mother	☐ Father	☐ Brother/sister	☐ Grandparent
Snoring	☐ Mother	☐ Father	☐ Brother/sister	☐ Grandparent
Sleep apnea	☐ Mother	☐ Father	☐ Brother/sister	☐ Grandparent
Restless leg syndrome	☐ Mother	☐ Father	☐ Brother/sister	☐ Grandparent
Sleepwalking/talking	☐ Mother	☐ Father	☐ Brother/sister	☐ Grandparent
Nightmares	☐ Mother	☐ Father	☐ Brother/sister	☐ Grandparent
Other:	☐ Mother	☐ Father	☐ Brother/sister	☐ Grandparent

6025-0003
(04/2018)

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MEDICAL AND PSYCHIATRIC HISTORY

Past Medical History

☐ Sinus problems	☐ Morning headaches/migraines	☐ Cranio-facial disorders
☐ Chronic bronchitis or cough	☐ Poor or delayed growth	☐ Thyroid problems
☐ Asthma	☐ Excessive weight	☐ Autism
☐ Frequent colds or flu	☐ Hearing problems	☐ Developmental delay
☐ Frequent ear infections	☐ Speech problems	☐ Hyperactive/ADD/ADHD
☐ Frequent strep throat infections	☐ Cerebral palsy	☐ Anxiety/Panic attacks
☐ Difficulty swallowing	☐ Heart disease	☐ Obsessive compulsive disorders
☐ Acid reflux (GERD)	☐ High blood pressure	☐ Depression
☐ Vision problems	☐ Sickle cell anemia	☐ Learning disability
☐ Seizures/epilepsy	☐ Chromosome disorders: (Trisomy 21, etc)	☐ Behavior disorders
☐ Severe head injury	☐ Skeletal disorders: (dwarfism, etc.)	

List any major medical conditions or illnesses that are not listed, or elaborate on above problems:

_____

_____

_____

_____

Please list all current medications and dosages:

_____ _____ _____

_____ _____ _____

_____ _____ _____

Surgeries and Hospitalizations

Has your child ever had their tonsils removed?	If yes, at what age:
Has your child ever had their adenoids removed?	If yes, at what age:
Has your child ever had ear tubes?	If yes, at what age:

Please list any additional hospitalizations or surgeries:

_____

_____

_____

_____

Health Habits

Does your child drink caffeinated beverages (energy drinks, soda, tea, coffee, etc.) If yes, what and how much per day: _____

Current School Performance

Is your child attending school?		Yes	No		
Is your child in any special education classes?		Yes	No		
How many school days has your child missed so far this year		_____ days			
Child's grades this year:	☐ Excellent	☐ Good	☐ Average	☐ Poor	☐ Failing
Child's grades last year:	☐ Excellent	☐ Good	☐ Average	☐ Poor	☐ Failing

Allergies and Sensitivities

Tape allergies:	If yes, describe or list:
Latex allergies:	If yes, describe or list:
Medication allergies:	If yes, describe or list:
Other:	If yes, describe or list:

Person completing this child sleep questionnaire/relationship to child:

Name: _____ **Relationship:** _____

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