PEDIATRIC SLEEP QUESTIONNAIRE
COMPREHENSIVE SLEEP DISORDER CENTER
ROBERT WOOD JOHNSON UNIVERSITY HOSPITAL
UMDNJ – ROBERT WOOD JOHNSON MEDICAL SCHOOL

These questionnaires is to obtain necessary information regarding your child's medical history and sleep related problems and will be used to help interpret your child's sleep study. Please answer the following questions by filling in the blanks or checking the appropriate response. You may omit questions that you feel do not apply to your child or that you do not wish to answer. Bring this form when you first come to the clinic or the sleep laboratory. Your cooperation is appreciated and your confidentiality assured.

Today's date: _____

Child's Name: _____ Sex: M _____ F _____

Birthdate: _____ Age: _____ Height: _____ Weight: _____

Mother's name: _____Father's name: _____

Address: _____

_____

Phone Number (Home): _____(Work): _____
(Including area code)

Referring Physician:
Name: _____

Address: _____

Phone Number: _____ Fax Number: _____
(Including area code)

If there is another physician that you would like us to send a copy of your report, you must provide us with the full name and address below:

_____

_____

_____

Has your child had a previous sleep study? Yes_____ No_____
If yes, where was the study done? _____

Date of study: _____

CLINICAL HISTORY:.

Please describe in your own words the reason you sought or are seeking this evaluation for you child.

_____

_____

_____

Does your child have any of the following problems regularly (once a week or more) during sleep?

Problem	No	Yes	If Yes, Age of Onset	Days per week
a. Snoring or Noisy Breathing				
b. Choking and Gasping in Sleep				
c. Stopping Breathing				
d. Struggling to Breathe				
e. Mouth Breathing/Trouble Breathing Through Nose				
f. Difficulty Swallowing/Drooling				
g. Restless Sleep/Tossing and Turning				
h. Frequent Leg Movements				
i. Teeth Grinding				
j. Sleep Walking				
k. Body Rocking/Head Banging				
l. Awakening Frightened/Screaming				
m. Bed Wetting				
n. Night Sweating				

Does your child have any of these problems?

Problem	No	Yes	If Yes, Age of Onset
a. Enlarged Tonsils			
b. Enlarged Adenoids			
c. Nasal allergies/Hay fever			
d. Asthma			
e. Frequent Cold/Sore Throat			
f. Frequent Ear Infections			
g. Frequent Morning Headaches			
h. Excessive Weight Gain			
i. Failure to Gain Weight			
j. Stomach Acid Reflux			
k. Neurologic or Muscular Disorder			
l. Genetic Disease			
m. Craniofacial Disorder			
n. Developmental Disability			
o. Hyperactivity			
p. Difficulties Paying Attention			
q. Irritability or Mood Swings			
r. Recent Decrease in School Performance			
s. Frequent Leg Pain or Discomfort			
t. Frequent Rubbing of Legs			
ANY OTHER DIAGNOSED ABNORMALITIES:			

Has your child had surgery for any of the following?

Problem	No	Yes	If Yes, Date of Surgery
a. Enlarged Tonsils			
b. Enlarged Adenoids			
c. Craniofacial Disorder			
OTHER:			

SLEEP HISTORY:

What time does your child usually go to bed on weekdays? _____ weekends? _____

What times does your child usually wake up on weekdays? _____ weekends? _____

How long does your child read, watch TV or do other activities after going to bed? _____(minutes)

How long does it usually take your child to fall asleep after all other activities are over? _____(minutes)

On a average night, how many times does your child wake up?

____Never
____1 or 2 times
____3 or 4 times
____5 or 6 times
____7 or more times

If your child does wake up during the night, how long does it usually take for him/her to go back to sleep?

____ 10 minutes or less
____ 10 to 30 minutes
____ 30 minutes to an hour
____ More than an hour

How many days a week does your child wake up early and then cannot go back to sleep?

____ Never
____ 1 or 2 days per week
____ 3 or 4 days per week
____ 5 or more days per week

How would you describe the quality of your child's sleep?

____ Excellent
____ Good
____ Fair
____ Poor

What is your child's usual sleeping position?

____ Stomach
____ Side
____ Back
____ Propped up with pillows

How many nights a week does your child sleep in the same room as you or another primary caretaker?

____ 1 or 2 days per week
____ 3 or 4 days per week
____ 5 or more days per week
____ Does not apply

Is your child excessively sleepy or tired during the day? Yes _____ No_____

How often does your child take naps?

____ Rarely or never
____ 1 or 2 times per week
____ 3 or 4 times per week
____ 5 or more times per week
____ More than once a day

If your child naps, how long do the naps last?

____ Between 10 and 30 minutes
____ Between 30 and 60 minutes
____ Between 1 and 2 hours
____ More than 2 hours

Is there anything else that is unusual about your child's sleeping or breathing during sleep?

_____

_____

_____

MEDICATION HISTORY:

Is your child presently taking any prescription or non-prescription medication (other than vitamins)?

Yes _____ No_____

If yes, please list.

Type	Amount	How Often
_____	_____	_____
_____	_____	_____
_____	_____	_____

Has your child taken any antibiotics in the past four weeks?

Yes _____ No _____

If yes, name of drug _____

Date of most recent dose _____