EPIWORTH SLEEPINESS SCORE _____

Physician:

Sleep Clinic **LABEL**

New Patient

HISTORY:

1. Who referred your child to the sleep clinic _____.

2. Was your child born full term and came home from the hospital with mom? ____ If no, please explain _____.

3. Please list all of your child's medical and mental health concerns (Asthma, ADHD, etc.)_____.

4. Please list any past surgeries (tonsils and adenoids removed) _____

_____.

5. Is there a history of anyone in the family with a sleep problem (snoring, difficulty falling asleep, restless _____.

6. Is there any smoking in the home or around your child _____.

7. Is your child in school? _____If so, what grade in school _____.

8. Do they receive any special services at school? _____.

9. Does your child have any behavior problems at home or at school? _____ If yes, please explain _____.

10. Does your child take any medications?____ If yes, please list medication, dose and time they take it _____

_____.

11. Development and behavior, at what age did your child:

roll over _____ sit alone _____crawl _____stand alone _____

walk alone_____ first words_____ daytime potty train _____ nighttime potty train _____

12. Does your child have problems with:

seeing_____ hearing _____ coughing _____ stuffy nose _____ runny nose _____

breathing problems _____ joint pain _____skin problems _____ tummy problems ____

acid reflux_____ leg numbness_____ bedwetting _____ constipation _____ diarrhea _____

speech delay ____ anxiety _____ depression _____ bedtime fears _____ hyperactive ____

lack of self-control _____ developmental delays _____ over weight _____

If you answered yes, please explain: _____

_____

SLEEP HISTORY:

1. What are your child's sleep problems?_____.

2. What have you done at home to help your child's sleep problem?_____

_____.

3. Has your child had a sleep study done?_____ If yes, when and where _____

_____.

4. Does your child snore?_____ If yes, how loud is it?_____.

5. Does your child complain of leg pains or the urge to move their legs at night or in the evening? _____ If yes, what does it feel like_____. What makes it better?_____. Or what makes it worse _____ .

6. Do you ever have to rub your child's leg?_____.

7. Does the child or anyone in the family have a history of low iron?_____.

If so, who in the family?_____.

Does your child ever: (please indicate how often, occasionally (< 1 time a month), sometimes (1-2 times per week), frequently (>3 times per week)

stop breathing while sleeping_____ fall asleep at school _____

mouth breathing_____ falls asleep in the car _____

gasp/choke at night _____ gets along well with others _____

sweats at night _____ sleep terrors _____

have restless sleep _____ night mares _____

noisy breathing _____ sleep walking _____

sleeps through the night _____ sleep talking _____

difficult to wake in the morning _____ sleepy during the day _____

bedwetting _____ headache in the morning _____

poor sleeper _____ awake in the night _____

difficulty to fall asleep _____ other _____

Comments: _____

_____

_____.

SLEEP SCHEDULE:

1. Weekday bedtime ____ Weekday wake up time ____ How long does it take to fall asleep_____ Weekend bedtime____ Weekend wake up time_____ How many times did they wake up _____ Are thing different in the summer? _____

2. How long does it take your child to go back to sleep after they wake up?_____
_____

3. How long does it take your child to get up in the morning?_____ Who wakes your child up in the morning? _____

4. Does your child nap during the day?____ If yes, how often and long _____.

When your child goes to sleep: (describe the setting)

own room_____ own bed _____ lights on _____

share room _____share bed_____ what size bed_____

night light on_____ TV on _____ cell phone in room _____

parents lay in bed _____ pets in room _____computer in room_____

Describe bedtime routine: _____
_____

_____.

What are your goals for your appointment today?_____
_____

_____.