Label

SSM Health Cardinal Glennon Children's Hospital

Pediatric Sleep and Research Center

SSM Health Cardinal Glennon Children's Hospital at SSM Health St. Joseph Hospital

Date:_____ Date of Study:_____
Name:_____ DOB:_____
Address:_____ Phone:_____
_____ Cell:_____
Parents Name:_____ Wk:_____
Referring Doctor:_____ Phone#:_____
Family Doctor or Pediatrician:_____ Phone#:_____
Current Sleep Problems:_____
_____
_____

Please Answer YES or NO

Does your child:

Snore:_____(Loudly:_____ Continuously:_____)

Have Noisy Breathing:	_____	Change color:	_____
Have frequent sinus problems:	_____	Choke:	_____
Have awake breathing problems:	_____	Turn pale:	_____
Become congested:	_____	Turn blue:	_____
Have frequent colds:	_____	Stop breathing:	_____
Cough or wheeze at night:	_____	Gasp for air:	_____
Have a tracheostomy:	_____	Have GI reflux:	_____
Receive oxygen therapy:	_____	Currently on CPAP:	_____

Require special treatment (suction, aerosol treatments, ect):_____

Sleep or Health Problems:

Attention problems:	_____	Bedwetting:	_____
Frightening dreams:	_____	Leg pains:	_____
Tooth grinding:	_____	Head banging:	_____
Humming while falling asleep:	_____	Body rocking:	_____
Sleepy during the day:	_____	Night sweats:	_____
Difficulty falling asleep:	_____	Night waking:	_____
Difficult to awaken:	_____	Hyperactivity:	_____
Wake during night:	_____	Stomach pain:	_____
Behavioral problems:	_____	Night terrors:	_____
Very emotional or anxious:	_____	Overweight:	_____
Sleep at school:	_____	Falling asleep at inappropriate times:	_____
Sleep through the night:	_____		

If you answered YES to any above questions, please specify:_____
_____
_____
_____
_____

Please fill out questionnaire and bring with you to your appointment.

Pediatric Sleep and Research Center

Sleeping information:

What time does child:

Go to sleep:	weekdays_____	weekends_____
Awaken:	weekdays_____	weekends_____
Naps:	length _____	# per day _____

Does the Child:

Sleep in their own room: _____	Sleep with parents: _____
Share a room with siblings _____	Share a bed with siblings: _____
Sleep in bed or crib: _____	Sleep with lights on: _____
Listen to music to fall asleep: _____	Watch tv to fall asleep: _____

Medical History

Height:_____ Weight:_____ (approximate if not known)

Previous Hospitalizations and diagnostic testing (year and diagnosis):_____
_____
_____
_____

Tonsil and Adenoid Removal (when and where):_____

Previous surgeries:_____
_____

Current Medications: (Drug and Dosage)

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Family History:

Sleep Disorders (what & whom):_____
_____

Asthma or other lung disease (what & whom):_____
_____

Other: _____
_____

Allergies: (medication/latex)

_____

Please fill out questionnaire and bring with you to your appointment.