Label

SSM Health Cardinal Glennon Children's Hospital

Pediatric Sleep and Research Center

SSM Health Cardinal Glennon Children's 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.

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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.