SSMHealth

PATIENT LABEL

Sleep Clinic New Patient Questionnaire

Dr. H. Thomas Johnson

DEMOGRAPHICS:

Date:_____ Child's Name:_____ Birthdate:_____ Age:_____
Address:_____ Phone: _____
Gender: _____ Racial/Ethnic Background: _____
Person Filling Out Questionnaire: _____ Relationship to Patient: _____

HISTORY:

Who referred your child to the sleep clinic _____
Was your child born full term and came home from the hospital with mom? _____
If no, please explain _____
Please list all of your child's medical and mental health concerns *(asthma, ADHD, etc.)* _____
_____
_____
Please list any past surgeries *(tonsils and adenoids removed, etc.)* _____
_____
Is there a history of anyone in the family with a sleep problem *(snoring, difficulty falling asleep, restless)* _____
_____
Who and which problem?_____
Who lives at home? _____
Is there any smoking in the home or around your child? _____
What grade is your child in?_____
Type of grades your child receives: _____
Do they receive any special services at school like an IEP or resource class?_____
_____
Does your child have any behavior problems at home or at school? _____
If yes, please explain: _____
Does your child have any allergies to medications? _____
Please list your child's medications:_____
_____

SLEEP HISTORY:

What are your concerns regarding your child's sleep?_____
What have you tried to fix your child's sleep?_____
_____
What are your expectations? _____
_____
Has your child had a sleep study before? If so, when, where, and what were the results? _____
_____
Does your child snore?____ For how many years? ____
If they snore, how loud is it?_____
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 _____
mouth breathing_____
gasp/choke at night_____
sweats at night _____
have restless sleep _____
noisy breathing_____
sleeps through the night_____
difficult to wake in the morning _____
fall asleep at school_____
falls asleep in the car_____
gets along well with others_____
sleep terrors _____
nightmares _____
sleep walking _____
sleep talking _____
sleepy during the day _____

bedwetting_____ headache in the morning _____
is a poor sleeper_____ awakens in the night _____
resists going to bed _____ problems falling asleep_____
Comments *(describe a typical sleep terror, etc.)*: _____
_____
_____

In the evening or at night, does your child have:
_____ Leg Pains
_____ Weird feelings in their legs
_____ Urge to move their legs
If yes, what does it feel like?_____
What makes it better? _____
What makes it worse? _____
Do you ever have to rub your child's legs? _____
Does the patient have a history of low iron? _____
Does anyone in the family have a history of low iron?_____
Does anyone have high iron? _____
Did anyone in the family ever have Hemochromatois or liver disease from an unknown cause? _____

SLEEP SCHEDULE:
Weekday bedtime: _____ Weekday wake time: _____ How long to fall asleep? _____
Weekend bedtime: _____ Weekend wake time: _____
How many awakenings during night: _____
If they wake during night, how long does it take them to fall back asleep?_____
How long does it take to wake them up in the morning? _____
Do they use an alarm, does the caregiver wake them, or do they wake on their own?_____
Is summer break any different? _____ If yes, bedtime: _____ Wake time: _____
Number of days each week that child takes a nap: _____
Nap start time: _____ End time: _____

When your child goes to sleep: *(describe the setting)*
Own Room _____ Lights on _____
Own Bed _____ Night light on _____
Share a room with siblings _____ TV on _____
Share a bed _____ If so, what size? _____ Cell phone in room _____
Parent lays in bed with child _____ Texting in room _____
Do pets sleep with them? _____ Computer in room _____
If they have a night light, what color is it? _____
Describe bedtime routine (activities between dinner and lights out): _____
_____
_____
_____
Has your child been sick in the last 4 weeks? _____
If so, how long ago did they get better?_____
Does your child drink caffeine/energy drinks? _____ How many per day? _____
What time is the last caffeine/energy drink of the day? _____
How does your child exercise during the day?_____

Development and Behavior - If your child is less than 3 yrs old, please tell us:
When did your child first *(your best guess is fine)*:
Roll Over _____ Walk Alone _____
Sit Alone _____ Speak First Words _____
Crawl _____ Become Day Toilet Trained _____
Stand Alone _____ Become Night Toilet Trained _____

Does your child have difficulty with any of the following:

Seeing _____
Hearing _____
Coughing _____
Stuffy Nose _____
Runny Nose _____
Breathing Problems _____
Joint Aches/Pains _____
Skin Problems _____
Abdominal Pains _____
Acid Reflux _____
Leg Numbness _____
Urinating/Bedwetting _____
Constipation _____
Diarrhea _____
Speech Delay _____
Worries/Anxiety _____
Depression _____
Bedtime Fears _____
Hyperactive _____
Lack of Self-Control _____
Developmental Delay _____
Weight Management _____

Name: _____ Date: _____

Modified Epworth Sleepiness Scale

How likely is your child to actually doze off or fall asleep in the following situations, in contrast to just feeling tired? This refers to usual daily life in recent times. Even if your child has not done some of these things recently, think about how the activities would affect your child. Use the following scale to choose the most appropriate number for each situation.

0 = Would never doze or sleep
1 = Slight chance of dozing or sleeping
2 = Moderate chance of dozing or sleeping
3 = High chance of dozing or sleeping

Select a number (0 to 3) for each of the 8 boxes.

Situation	Chance of dozing or falling asleep (0-3)
Sitting and reading	_____
Watching TV	_____
Sitting, inactive in a public place (e.g., a class room or movie theater)	_____
As a passenger in a car for an hour without a break	_____
Lying down to rest in the afternoon	_____
Sitting and talking	_____
Sitting quietly after lunch	_____
While playing video game	_____
TOTAL:	_____