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Pediatric Sleep Program (Please fill out and bring with you to sleep study/ office visit)

Date: _____ Date of Study: _____

Name: _____ DOB: _____

Address: _____ Phone: _____

_____ Cell: _____

Parents Name: _____ WK: _____

Referring Doctor: _____ 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 GI Reflux: _____ Receive Oxygen: _____

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: _____

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Difficulty Falling Asleep: _____ Night Walking: _____

Difficult to Awaken: _____ Hyperactivity: _____

Wake During the Night: _____ Stomach Pain: _____

Behavioral Problems: _____ Night Terrors: _____

Very Emotional or Anxious: _____ Overweight: _____

Sleep at School: _____ Fall Asleep at inappropriate times:_____

Sleep Through the Night: _____

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

_____

_____

_____

_____

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: _____

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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 and Whom): _____

_____

Asthma or other Lung disease (What and Whom): _____

_____

Other: _____

_____

Allergies: (medication/ latex) _____

_____