**Pediatric Sleep History**

**Address:**

**Phone numbers:**
- Home (______)
- Cell (______)
- Work (______)
- Other (______)

**Form completed by:**

**Date completed:**

**Referring Doctor Name and Address**

**Primary Care Doctor Name and Address**

---

**PLEASE ANSWER THESE QUESTIONS TO HELP US UNDERSTAND YOUR CHILD’S SLEEP**

**What are your concerns about your child’s sleep?**

______________________________________________________________________________________________________________________________

______________________________________________________________________________________________________________________________

**At what age did sleep problems begin?**

______________________________________________________________________________________________________________________________

**Please describe how the problem has changed over time:**

______________________________________________________________________________________________________________________________

**What have you tried to help your child’s sleep problems?**

______________________________________________________________________________________________________________________________

---

**On typical WEEKDAYS or SCHOOL DAYS:**

- My child’s bed time is _____ □ pm □ am.
- It takes him/her _____ □ min □ hours to fall asleep.
- My child’s wake up time is _____ □ pm □ am.

**On typical WEEKENDS or DAYS OFF:**

- My child’s bed time is _____ □ pm □ am.
- It takes him/her _____ □ min □ hours to fall asleep.
- My child’s wake up time is _____ □ pm □ am.

**Is your child difficult to awaken?** □ YES □ NO

---

**CHECK THE BOX TO ANSWER ‘YES’ OR ‘NO’ FOR EACH QUESTION:**

- □ YES □ NO **Does your child have a bedtime routine?** If YES: mark which activities apply.
  - □ Favorite toy nearby to fall asleep
  - □ Needs to be fed to fall asleep
  - □ Needs to be rocked to sleep
  - □ Needs someone else in the room
  - □ Can only fall asleep in your bed
  - □ Watches TV or video to fall asleep
  - □ Other (please describe) ______________________________________________________________________________________

- □ Plays on computer
  - □ Plays video games
  - □ Listen to music
  - □ Read a story
  - □ Bath or shower
  - □ Prayer

- **How long does your child’s bedtime routine usually take?** _____ □ min □ hours

- **Who usually puts your child to bed?** □ Mother □ Father □ Both parents □ Self
  - □ Other: ________________________________________________
**CHECK THE BOX TO ANSWER ‘YES’ OR ‘NO’ FOR EACH QUESTION:**

<table>
<thead>
<tr>
<th>Question</th>
<th>Options</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Does your child share a bedroom with someone else?</strong></td>
<td>□ YES □ NO</td>
</tr>
<tr>
<td>If YES: Whom?</td>
<td>_____________________________________________________________________</td>
</tr>
<tr>
<td><strong>Does your child have his/her own bed?</strong></td>
<td>□ YES □ NO</td>
</tr>
<tr>
<td>What kind of bed does your child have:</td>
<td>□ Crib □ Twin □ Full □ Queen □ King □ Bunk bed □ Water bed □ Your bed □ Other: __________________________________________________________________</td>
</tr>
<tr>
<td><strong>Where does your child usually fall asleep?</strong></td>
<td>□ Own bed □ Parent’s bed □ Sibling’s bed □ Other: __________________________________________________________________</td>
</tr>
<tr>
<td><strong>Where does your child sleep most of the night?</strong></td>
<td>□ Own bed □ Parent’s bed □ Sibling’s bed □ Other: __________________________________________________________________</td>
</tr>
<tr>
<td><strong>Where does your child usually wake up?</strong></td>
<td>□ Own bed □ Parent’s bed □ Sibling’s bed □ Other: __________________________________________________________________</td>
</tr>
</tbody>
</table>

**Do pets sleep on your child’s bed?**  □ YES □ NO

**Is there a TV or computer in your child’s bedroom?** □ YES □ NO

**Does your child read or listen to music in bed?** □ YES □ NO

**Does your child feel safe in his/her bedroom?** □ YES □ NO

**Do you enforce regular bedtimes for your child?** □ YES □ NO

How long does your child usually spend in his or her bedroom before going to sleep? _____ □ min □ hours

**Does your child have difficulty falling asleep at night** □ YES □ NO

If YES: Why do you think your child has difficulty falling asleep? __________________________________________________________________

**Does your child wake up during the night?** □ YES □ NO

If YES: How many times does he or she USAUALLY wake up? _______________________

How long does your child USAUALLY stay awake? _____ □ min □ hours

What wakes your child up? __________________________________________________________________

**Does your child have difficulty falling back to sleep after awakening?** □ YES □ NO

**Is your child too sleepy during the day?** □ YES □ NO

If YES: Please describe WHY you think your child is too sleepy during the day _______

**Does your child take naps during the day?** □ YES □ NO

If YES: How many naps does your child USAUALLY take per day? ______

How long is the USUAL nap? _____ □ min □ hours

Does your child wake up from the nap feeling rested? □ YES □ NO

Where does your child nap? □ His/her bed □ Your bed □ Crib □ Car □ School bus □ Living room/couch □ In school □ Other: __________________________
Does your child have any of the following symptoms? If YES, please check the box:

- □ Snoring
- □ Wakes up gasping for breath or choking
- □ Stops breathing during sleep
- □ Struggles to breathe during sleep
- □ Restless sleep
- □ Sweats excessively while asleep
- □ Wets the bed while asleep
- □ Cannot sleep on his/her back
- □ Strange sleeping positions
- □ Grinds teeth while asleep
- □ "Acts out" dreams
- □ Frequent nightmares
- □ Frequent sleepwalking
- □ Frequent talking in his/her sleep
- □ Falls asleep in odd situations or places
- □ Cannot keep his/her legs still prior to falling asleep
- □ Has an irresistible need to move his/her legs when lying down or sitting
- □ Wakes up with heartburn or a sour, stomach-acid taste (acid reflux or indigestion)
- □ Wakes up with a sore throat
- □ Wakes up with heart beating fast or missing beats
- □ Wakes up confused and disoriented
- □ Often has a headache when he/she wakes up
- □ Often wakes up with nausea or wanting to vomit, or vomits
- □ Often has a dry mouth when he/she wakes up.
- □ Shortness of breath or coughing that is worse at night
- □ Large tonsils
- □ Difficulty falling asleep due to nasal congestion
- □ Difficulty falling asleep due to pain
- □ Prefers to sleep with parents
- □ Refuses to go to bed
- □ Frequently makes excuses to get out of bed at night
- □ Problems with friendships or social interactions because of sleepiness
- □ Problems with learning because of sleepiness
- □ Problems with concentration and attention because of sleepiness
- □ Fears about sleeping, bedroom, or the dark
- □ Difficulty falling asleep due to sadness or depression
- □ Difficulty falling asleep due to being worried or anxious
- □ Often has sudden weakness (not dizziness) in the knees, neck, or arms when he/she is startled, laughing, angry, or emotional
- □ Suddenly falls asleep without warning
- □ “Growing pains”
- □ Anger or hyperactive outbursts that may be related to sleepiness
- □ Has seizures while sleeping
- □ Claustrophobia
- □ Weight gain

Updated 2/10
CHECK THE BOX TO ANSWER ‘YES’ OR ‘NO’ FOR EACH QUESTION:

□ YES □ NO  Does your child have regular meal times?
What time does your child usually eat
Breakfast _____ □ am □ pm
Lunch _____ □ am □ pm
Dinner _____ □ am □ pm
Snacks _____ □ am □ pm

□ YES □ NO  Does your child DRINK or EAT within 2 hours of bedtime?
If YES, how many ounces does your child drink? ______ ounces of ______________________
What does he or she eat? __________________________

□ YES □ NO  Does your child get up to eat in the middle of the night?

□ YES □ NO  Does your child drink any beverages containing CAFFEINE?
If YES: Please give more details about HOW MUCH and HOW OFTEN.
Coffee: _______________________________________________________________________
Hot Tea: _______________________________________________________________________
Iced Tea: _____________________________________________________________________
Caffeinated soda (including Mountain Dew, Dr. Pepper, Coke, Pepsi, diet soda, and energy drinks): ______

How many hours of TV does your child watch in a DAY? _____ hrs  in a WEEK? _____ hrs
How many hours of VIDEO GAMES does your child play in a DAY? _____ hrs  in a WEEK? _____ hrs
How many hours does your child spend on the COMPUTER in a DAY? _____ hrs  in a WEEK? _____ hrs
What does your child do for PHYSICAL ACTIVITY or EXERCISE? ____________________________
_________________________________________________________________________________
_________________________________________________________________________________
_________________________________________________________________________________

RATE HOW SLEEPY YOUR CHILD FEELS DURING THE DAY

How likely is your child to DOZE OFF or FEEL SLEEPY (not just feeling tired or fatigued) in the following situations? This refers to how sleepy he or she has been RECENTLY (such as in the last TWO WEEKS). If your child has not been in these situations recently, try to IMAGINE how sleepy he or she would feel in these situations.

Use the following scale to choose (CIRCLE) the most appropriate number in each situation:

0 = My child would NEVER doze off
1 = My child would have a SLIGHT CHANGE of dozing off
2 = My child would have a MODERATE CHANGE of dozing off
3 = My child would have a HIGH CHANGE of dozing off

Chance of Dozing

0 1 2 3  In school
0 1 2 3  After school
0 1 2 3  Sitting quietly in a public place (such as in a movie, classroom, or church)
0 1 2 3  As a passenger in a car
0 1 2 3  Lying down to rest in the afternoon
0 1 2 3  Playing quietly with friends
0 1 2 3  Sitting quietly after a lunch
0 1 2 3  Watching TV

Updated 2/10
At what age did your child:  
Walk? ____ □ years □ months  
Talk? ____ □ years □ months

Does your child:  
□ Point to body parts  
□ Know his or her age  
□ Add / Subtract  
□ Say the alphabet  
□ Count (how high? ____ )  
□ Multiply / Divide  
□ Know his or her colors  
□ Write his or her name  
□ Read at grade level

□ YES □ NO  Is your child in school? If YES: What grade? ________________________

□ YES □ NO  Has he or she ever been HELD BACK a grade?

□ YES □ NO  Is he or she in SPECIAL EDUCATION classes?

□ YES □ NO  Does he or she have a LEARNING DISABILITY?

Have your child’s TEACHER(S) reported any of the following?  
□ Too sleepy  
□ Outbursts of anger  
□ Sad/Blue mood  
□ Falls asleep/naps in class  
□ Daydreams  
□ Disruptive in class  
□ Grades are falling  
□ Aggressive behavior  
□ Outbursts of hyperactivity  
□ Short attention span  
□ Stares into space  
□ Does not follow instructions  
□ Other: ____________________________________________________________

How are your child’s grades THIS YEAR?  
□ Excellent □ Good □ Average □ Poor

How were your child’s grades LAST YEAR?  
□ Excellent □ Good □ Average □ Poor

□ YES □ NO  Does your child have BEHAVIOR PROBLEMS?  
If YES: Please describe
________________________________________________________________________

□ YES □ NO  Has your child been LATE TO SCHOOL because of difficulty awakening in the morning?  
If YES: How many times this year? __________  How many times last year? __________

□ YES □ NO  Do you give your child any medicines or herbs (prescribed or over-the-counter) to HELP him or her GO TO SLEEP?  
If YES: Please list the name, dose, and frequency __________________

________________________________________________________

□ YES □ NO  Do you give your child any medicines or herbs (prescribed or over-the-counter) to HELP him or her STAY AWAKE?  
If YES: Please list the name, dose, and frequency __________________

________________________________________________________

Please list any MEDICATIONS your child CANNOT TAKE because of allergy or side effects:
________________________________________________________________________

□ YES □ NO  Does your child have allergies to LATEX?

Does your child have: □ Food Allergies □ Seasonal Allergies □ Environmental Allergies

Please list ALL the medications (including over-the-counter and nutritional supplements) that your child is CURRENTLY taking:

<table>
<thead>
<tr>
<th>Name</th>
<th>Dose</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

□ YES □ NO  Are your child’s IMMUNIZATIONS up to date?
**Does your child HAVE NOW or HAD IN THE PAST any of the following? Check all that apply:**

<table>
<thead>
<tr>
<th>□ Acid reflux (GERD)</th>
<th>□ Chronic pain</th>
<th>□ Heart murmur</th>
<th>□ Pneumonia</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ ADD or ADHD</td>
<td>□ Cystic Fibrosis</td>
<td>□ Heart problems</td>
<td>□ Problems at birth</td>
</tr>
<tr>
<td>□ Adenoids removed</td>
<td>□ Depression</td>
<td>□ Heart surgery</td>
<td>□ Poor appetite or picky eater</td>
</tr>
<tr>
<td>□ ALTE or near-SIDS</td>
<td>□ Developmental delay</td>
<td>□ Head injury</td>
<td>□ Seasonal allergies</td>
</tr>
<tr>
<td>□ Anemia</td>
<td>□ Diabetes</td>
<td>□ High blood pressure</td>
<td>□ Seizures or seizure disorder</td>
</tr>
<tr>
<td>□ Anxiety</td>
<td>□ Ear tubes</td>
<td>□ High cholesterol</td>
<td>□ Sinus problems</td>
</tr>
<tr>
<td>□ Asthma</td>
<td>□ Environmental allergies</td>
<td>□ HIV and/or AIDS</td>
<td>□ Slow growth</td>
</tr>
<tr>
<td>□ Bedwetting</td>
<td>□ Fainting</td>
<td>□ Injury to nose</td>
<td>□ Speech problems</td>
</tr>
<tr>
<td>□ Behavior problems</td>
<td>□ Febrile convulsions</td>
<td>□ Kidney problems</td>
<td>□ Thyroid problems</td>
</tr>
<tr>
<td>□ Born premature</td>
<td>□ Frequent ear infections</td>
<td>□ Mental illness</td>
<td>□ Tonsillectomy</td>
</tr>
<tr>
<td>□ Brain injury</td>
<td>□ Headaches</td>
<td>□ Needs/Has glasses</td>
<td>□ Overweight or Obesity</td>
</tr>
<tr>
<td>□ Cancer</td>
<td>□ Hearing problems</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Please list ANY OTHER MEDICAL PROBLEMS not mentioned above:**
______________________________________________________________________________________________________________________________
______________________________________________________________________________________________________________________________

**Please list any OPERATIONS or HOSPITALIZATIONS your child has had:**

<table>
<thead>
<tr>
<th>Approximate Date</th>
<th>Type of surgery or Reason for hospitalization</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Was your child born □ Full term □ Premature**

**What was your child’s birth weight? _____ lbs _____ oz**

**Was the pregnancy, labor, or birth complicated?** IF YES, please describe:
______________________________________________________________________________________________________________________________
______________________________________________________________________________________________________________________________

**Do your child have any BLOOD RELATIVES who have or had (check all that apply):**

<table>
<thead>
<tr>
<th>□ ADD / ADHD</th>
<th>□ Depression</th>
<th>□ Insomnia</th>
<th>□ Sleep apnea</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Alzheimer’s Disease</td>
<td>□ Diabetes</td>
<td>□ Kidney disease</td>
<td>□ Sleep problems</td>
</tr>
<tr>
<td>□ Allergies</td>
<td>□ Headaches / Migraines</td>
<td>□ Loud snoring</td>
<td>□ Sleepwalking</td>
</tr>
<tr>
<td>□ Anemia</td>
<td>□ Hyperactivity</td>
<td>□ Mental illness</td>
<td>□ Snoring</td>
</tr>
<tr>
<td>□ Anxiety</td>
<td>□ Emphysema / COPD</td>
<td>□ Narcolepsy</td>
<td>□ Stroke / Brain Hemorrhage</td>
</tr>
<tr>
<td>□ Asthma</td>
<td>□ Epilepsy / Seizures</td>
<td>□ Obesity</td>
<td>□ Thyroid disease</td>
</tr>
<tr>
<td>□ Bipolar disorder</td>
<td>□ Excessive sleepiness</td>
<td>□ Migraine headaches</td>
<td>□ Tuberculosis</td>
</tr>
<tr>
<td>□ Brain tumor</td>
<td>□ Heart disease</td>
<td>□ Restless Legs Syndrome</td>
<td></td>
</tr>
<tr>
<td>□ Cancer or Leukemia</td>
<td>□ High blood pressure</td>
<td>□ Schizophrenia</td>
<td></td>
</tr>
<tr>
<td>□ Learning problems</td>
<td>□ High cholesterol</td>
<td>□ SIDS or Crib Death</td>
<td></td>
</tr>
</tbody>
</table>

**Please list any other significant MEDICAL CONDITIONS that RUN IN THE FAMILY:**
______________________________________________________________________________________________________________________________
______________________________________________________________________________________________________________________________
□ YES □ NO  Does your child have siblings?

If YES: List the name, age, and sex of the siblings

NAME_________________________ AGE______ SEX______ NAME_________________________
NAME_________________________ AGE______ SEX______ NAME_________________________
NAME_________________________ AGE______ SEX______ NAME_________________________

Who else lives at home with your child?

NAME________________________________ RELATIONSHIP__________________________
NAME________________________________ RELATIONSHIP__________________________
NAME________________________________ RELATIONSHIP__________________________
NAME________________________________ RELATIONSHIP__________________________
NAME________________________________ RELATIONSHIP__________________________

□ YES □ NO  Are there any smokers in the home?
□ YES □ NO  Are there any guns in the home?
□ YES □ NO  Is there anyone in the home who has a problem with drugs or alcohol?
□ YES □ NO  Does the family have any pets?

Please check any symptoms that have bothered your child in the LAST TWO WEEKS.

In the LAST TWO WEEKS my child has had:

<table>
<thead>
<tr>
<th>Eyes</th>
<th>Pulmonary</th>
<th>Constitutional</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Trouble seeing</td>
<td>□ Wheezing</td>
<td>□ Underweight</td>
</tr>
<tr>
<td>□ Needs glasses</td>
<td>□ Shortness of breath</td>
<td>□ Overweight</td>
</tr>
<tr>
<td>□ Eye irritation or discomfort</td>
<td>□ Nighttime cough</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Ears, Nose, Throat</th>
<th>Gastrointestinal</th>
<th>Psychological</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Ear pain</td>
<td>□ Acid reflux / heartburn</td>
<td>□ Aggressive / Angry a lot</td>
</tr>
<tr>
<td>□ Nosebleeds</td>
<td>□ Nausea / vomiting</td>
<td>□ Anxiety or Panic attacks</td>
</tr>
<tr>
<td>□ Stuffy or congested nose</td>
<td>□ Frequent stomach aches</td>
<td>□ Cries easily</td>
</tr>
<tr>
<td>□ Difficulty swallowing</td>
<td></td>
<td>□ Sad or blue mood / depression</td>
</tr>
<tr>
<td>□ Sore throat</td>
<td></td>
<td>□ Fidget</td>
</tr>
<tr>
<td>□ Sinus problems</td>
<td></td>
<td>□ Difficulty completing tasks</td>
</tr>
<tr>
<td>□ Nasal speech</td>
<td></td>
<td>□ Easily distracted</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Neck</th>
<th>Genitourinary</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Neck stiffness or pain</td>
<td>□ Urinary tract infections</td>
<td></td>
</tr>
<tr>
<td>□ Swollen neck glands</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Cardiovascular</th>
<th>Hematologic / Immunologic</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Chest pain</td>
<td>□ Abnormal bleeding</td>
<td>□ Doesn’t play like other kids</td>
</tr>
<tr>
<td>□ Tightness / pressure in chest</td>
<td>□ Infections</td>
<td>□ Poor coordination</td>
</tr>
<tr>
<td>□ Skipped heart beats</td>
<td></td>
<td>□ Poor eye contact</td>
</tr>
<tr>
<td>□ Poor circulation</td>
<td></td>
<td>□ Physical or emotional abuse</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Musculoskeletal</th>
<th>Skin</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Back or joint pain</td>
<td>□ Rash</td>
<td></td>
</tr>
<tr>
<td>□ Clumsy walking</td>
<td>□ Skin sores or lesions</td>
<td></td>
</tr>
<tr>
<td>□ Growing pains</td>
<td>□ Eczema</td>
<td></td>
</tr>
<tr>
<td>□ Poor coordination</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Neurologic</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Headaches</td>
<td>□ Underweight</td>
<td></td>
</tr>
<tr>
<td>□ Dizziness</td>
<td>□ Overweight</td>
<td></td>
</tr>
<tr>
<td>□ Fainting</td>
<td>□ Aggressive / Angry a lot</td>
<td></td>
</tr>
<tr>
<td>□ Tics</td>
<td>□ Anxiety or Panic attacks</td>
<td></td>
</tr>
<tr>
<td>□ Staring spells</td>
<td>□ Cries easily</td>
<td></td>
</tr>
</tbody>
</table>

Thank you for completing this questionnaire.