New Patient Pediatric Sleep Questionnaire
Seattle Children’s Pediatric Sleep Disorders Program

Sleep Lab and Clinic
Main Message: 206-987-5072
Fax: 206-987-8943

Child’s name ________________________________ Today’s date ____________

Birth date _______ Age ___  □ Male □ Female Height ___ in ___ cm Weight ___ lb ___ kg

Parents’ names ________________________________ Primary language spoken ______________

This questionnaire was completed by (relationship to child) ________________________________

Address ________________________________ City/ZIP ________________________________

Day phone ________________________________ Best time to call _______ a.m. ___ p.m.

Eve phone ________________________________ Best time to call _______ a.m. ___ p.m.

Alternative contact or message number __________________________ Need an interpreter? □ No □ Yes

Referring provider ________________________________

Insurance company ____________________________ □ Self-pay □ Other ________________

Briefly describe your child’s current sleep problem:
__________________________________________

__________________________________________

Does your child have any new or recent medical problems? □ No □ Yes, explain ________________

__________________________________________

__________________________________________

Does your child currently have (check all that apply):

□ Daytime cough □ Cold with runny nose □ Nighttime cough □ Seizure disorder

□ Nasal polyps □ Wheezing □ Bad breath □ Gastroesophageal reflux

□ Headaches □ Poor weight gain

__________________________________________
# New Patient Pediatric Sleep Questionnaire

## Medicines

Does your child take any **daily** prescription medicines?  
- [ ] No  
- [ ] Yes, list what taken:

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<tr>
<th>Medicine</th>
<th>Dose</th>
<th>Frequency</th>
<th>Date started</th>
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Does your child take any prescription medicine, on an **as-needed** basis?  
- [ ] No  
- [ ] Yes, list what is taken:

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<th>Medicine</th>
<th>Dose</th>
<th>Frequency</th>
<th>Date started</th>
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List all over-the-counter medicines, herbs or vitamins your child takes:

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## Family History

Are there other members of the family with sleep problems?  
- [ ] None  
- [ ] Unknown  
- [ ] Yes, explain:

________________________________________________________________________________________

Does anyone in the family snore?  
- [ ] Siblings  
- [ ] Father  
- [ ] Mother  
- [ ] Grandmother  
- [ ] Grandfather  
- [ ] Other

Does anyone in the family (other than patient) use breathing help at night time?  
- [ ] CPAP (if so, who __________________________ )  
- [ ] Bi-level PAP (if so, who __________________________ )

- [ ] Oxygen (if so, who __________________________ )

Have you had any children who have not survived?  
- [ ] No  
- [ ] Yes, cause of death __________________________

________________________________________________________________________________________
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**Social History**

Has your child missed more than the average amount of school/daycare due to illness?  ■ No  ■ Yes
Number of days missed in a year ____________________________
Do you have family or friends nearby who would help you in time of need?  ■ No  ■ Yes
Does your child get along well with other children?  ■ Yes  ■ No, explain ____________________________
Has your child needed any counseling for behavior concerns?  ■ No  ■ Yes, explain ________________
How often in the last year has your child gone to:  ■ The doctor’s office ____times  ■ The hospital____times
How many hours of TV and/or computer games does your child watch per day?  ______
If school-age, what grade? ______  Correct grade for age?  ■ Yes  ■ No, why?  ■ Held back a grade  ■ Moved up a grade
Progress in school  ■ Above average  ■ Special education service  ■ Average  ■ Below average  ■ NA
Is your child in daycare?  ■ No  ■ Yes, how many days/week? ______
List two typical dinners your child eats in the evening:

**Sleep Evaluation**

Have you ever had any previous evaluation for this sleep disturbance?  ■ No  ■ Yes, explain:

Have you ever had a test or measurement of your child’s nighttime oxygen levels?
■ No  ■ Yes  ■ Normal  ■ Abnormal  ■ Not sure

Have you ever had a polysomnogram or sleep study performed on your child?
■ No  ■ Yes  ■ Normal  ■ Abnormal  ■ Not sure

Diagnosis from polysomnography:
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At what age did your child first sleep through the night? __________ Years __________ Months

Does your child require any special routine or object to aid him/her in going to sleep, such as a pacifier, stuffed animal, special music, rocking, patting, etc.?

☐ No ☐ Yes, explain: _______________________________________________________

Does your child wake during the night?

☐ No ☐ Yes: ☐ First third of night ☐ Middle third of night ☐ Last third of night

Number of awakenings per night __________

With awakenings from sleep, does your child appear:

☐ Calm, but asleep
☐ Calm and awake
☐ Confused
☐ Agitated and/or violent
☐ Screaming in terror, but difficult to awaken

Does your child:

☐ State he/she is afraid, but does not appear to be afraid
☐ Return to sleep quickly after parent responds to child’s request (pat, rock, nurse, etc.)
☐ Cry self to sleep
☐ Sleep talk
☐ Sleep walk
☐ Bang head or rock when getting to or during sleep
☐ Teeth grind
☐ Have hallucinations upon falling asleep or upon awakening
☐ Have an inability to move his/her body (paralysis) upon falling asleep or upon awakening
☐ Have twitching of legs
☐ Have pain in legs
☐ Have difficulty falling asleep (takes more than 10 to 20 minutes for child to fall asleep once in bed)
☐ Act very fearful/terrified at bedtime
☐ Get headaches
☐ Sweat excessively
☐ Wet the bed

Does your child:

☐ Ever have sleep attacks, or suddenly and unexpectedly fall asleep?
☐ Become weak, especially when excited, angry or laughing?
☐ Fall asleep at school?
☐ Fall asleep in odd situations or places?
☐ Complain of being sleepy as far back as you can remember?
☐ Breathe through the mouth during the day?
☐ Breathe through the mouth during the night, while sleeping?
New Patient Pediatric Sleep Questionnaire

Snoring Habits

Does your child snore during sleep?  □ No  □ Yes: □ Barely audible  □ Can be heard inside his/her room  □ Can be heard outside the room  □ Disturbs household

At what age did you first notice your child snore? ______________________

How long has your child been snoring?  □ 2 weeks  □ 1 month  □ 2 to 6 months  □ 6 months to 1 year  □ Over 1 year  □ All their life

Is your child’s snoring worse when lying on his/her  □ Back  □ Stomach  □ Sides

Does your child like to sleep:  □ Flat  □ Supported by pillows  □ Sitting up in a chair  □ Other:

______________________________

Would you describe your child’s snoring as: □ Continuous  □ Intermittent  □ Associated with gasping or choking  □ Interrupted by long pauses of no breathing

Has your child ever stopped breathing during sleep?  □ No  □ Yes

Have you been concerned that your child may stop breathing during sleep?  □ No  □ Yes

If your child snores, does it worsen with cold symptoms?  □ No  □ Yes

If your child doesn’t typically snore, will he/she snore with cold symptoms?  □ No  □ Yes

Have you ever noticed that your child works hard to breathe at night?  □ No  □ Yes

Has your child’s skin color ever appeared dusky or blue at night?  □ No  □ Yes

Current Sleep Habits

What time does your child:

Go to sleep on school nights?  __________

Awaken on weekdays?  __________

Go to sleep on weekend nights?  __________

Awaken on weekends?  __________

Does your child:

Fall asleep in his/her own bed?  □ No  □ Yes

Nap weekdays?  □ No  □ Yes:  

□ Number of naps/day? ___  □ How long? ______

Nap weekends?  □ No  □ Yes:  

□ Number of naps/day? ___  □ How long? ______

Complain of feeling tired?  □ No  □ Yes

Get enough sleep?  □ No  □ Yes
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Who puts the child to bed? __________________________

Is the child put to bed: ☐ Awake ☐ Asleep

Does your child sleep: ☐ In your room ☐ In your bed ☐ In separate bedroom

☐ In his/her own bed ☐ With other siblings ☐ Other __________________________

Does your child take pop, soda, cocoa, tea or coffee before bed? ☐ No ☐ Yes: How much and when?

Does the child eat a snack before bedtime? ☐ No ☐ Yes: List snacks and when eaten:

Does your child on most nights:

☐ Repeatedly get out of bed ☐ Refuse to sleep alone

☐ Require a night light on ☐ Have frightening dreams just prior to or just after sleep onset

Is your child:

Difficult to get to bed? ☐ No ☐ Yes

Difficult to awaken? ☐ No ☐ Yes

Sleeping during the day? ☐ No ☐ Yes

Groggy in the morning? ☐ No ☐ Yes

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Morning Behavior

My child typically (check all that apply):

☐ Reports having a bad dream in the morning

☐ Wakes up looking tired

☐ Wakes up irritable and in a bad mood

☐ Is groggy and difficult to awaken in the morning

☐ Wakes up in a different room from where child fell asleep

☐ Complains of headaches in the morning

☐ Upon awakening has a feeling of being paralyzed

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Current respiratory treatments:

1. Use O2 (oxygen)? ☐ No ☐ Yes

   If yes: At ________ p.m.

   ________ hrs while awake

   ________ hrs during sleep

2. Use CPAP/BIPAP/Ventilator? ☐ No ☐ Yes

   If yes: At ________ cm/H₂O

3. Respiratory equipment company:

   __________________________

   Company’s location (city) __________________

   Phone __________________________

4. Satisfied with equipment company? ☐ Yes ☐ No
Herman Sleepiness Scale for Children

☐ My child is in _____ grade in school  ☐ My child is not in school (under 5 years old)

This scale was completed by: ☐ Child  ☐ Other (relationship to child) ____________________________

Instructions: Please pick a number rating and write it on the line after the sentences below as it applies to your child.

IMPORTANT!
This scale is for SLEEPINESS, or the ability to fall sleep (not tiredness or the feeling of being tired).

SLEEPINESS RATES  0 = NEVER  1 = RARELY  2 = FREQUENTLY  3 = ALWAYS

1. I (my child) become sleepy riding in a car. _________
2. I become sleepy listening to people talk. _________
3. I become sleepy doing my homework. _________
4. I become sleepy whenever I am still. _________
5. I become sleepy watching TV. _________
6. I become sleepy at the movies. _________
7. I become sleepy at church, temple or mosque. _________
8. I become sleepy at school. _________
9. I become sleepy reading anything. _________
10. I become sleepy after eating a meal. _________  SCALE TOTAL _________

Thank you for your time! This will help the sleep provider better evaluate your child.