Pacific Sleep Program

Portland & Astoria

Setting the standard in sleep medicine for over 30 years

Pediatric Sleep Evaluation Questionnaire

Directions

Please answer each of the following questions by writing in or choosing the best answer. This will help us know more about your family and your child. In cases where your child cannot directly answer, please provide an estimate based on parent's observations. These questions span children of many ages, so if a question appears inappropriate for your child's age please just ignore the question.

The Epworth Sleepiness Scale

How likely is your child to doze off or fall asleep in the following situations? Even if your child has not done some of these things recently, please think about how they would be affected in the circumstances listed. Use the following scale to choose the most appropriate number for each situation. If your child is too young to provide direct responses to these questions, please provide an estimate based on your observations of your child.

0 - would **NEVER** doze
1- **SLIGHT** chance of dozing
2- **MODERATE** chance of dozing
3- **HIGH** chance of dozing

Situation	**Chance of dozing (0-3)**
Sitting and reading	
Watching TV	
Sitting, inactive in a public place (e.g. a theater or a classroom)	
As a passenger in a car for an hour without a break	
Lying down to rest in the afternoon if you are able	
Sitting and talking to someone	
Sitting quietly after lunch	
Doing homework or taking a test	

FAMILY'S INFORMATION	
Parent/Guardian 1	Parent/Guardian 2
Name:	Name:
Age:	Age:
Relationship to patient:	Relationship to patient:
Occupation:	Occupation:
Marital Status:	Marital Status:

Persons Living in Home		
Name	Relationship	Age

CHILD'S INFORMATION

Child's name:	Child's gender: ✹ Male ✹ Female
Child's birthdate:	Child's age:

What are your major concerns about your child's sleep?

Does your child have any difficulties with school performance, and if so please tell us about them:

SCHOOL PERFORMANCE

CURRENT SCHOOL PERFORMANCE (if school-aged)

Your child's grade:

Has your child ever repeated a grade?	✹ No	✹ Yes
Is your child enrolled in any special education class?	✹ No	✹ Yes
How many school days has your child missed so far this year?		
How many school days did your child miss last year?		
How many school days was your child late so far this year?		
How many school days was your child late last year?		

Child's grades this year:	✹ Excellent	✹ Good	✹ Average	✹ Poor	✹ Failing
Child's grades last year:	✹ Excellent	✹ Good	✹ Average	✹ Poor	✹ Failing

SLEEP HISTORY

Weekday Sleep Schedule

Write in the amount of time your child sleeps during a 24-hour period **on weekdays** (add daytime and nighttime sleep): _____ hours _____ minutes

The child's usual bedtime on **weekday nights** : _____:_____

The child's usual waking time on **weekday mornings**: _____:_____

Weekend/Vacation Sleep Schedule

Write in the amount of time child sleeps during a 24-hour period **on weekends and vacations** (add daytime and nighttime sleep): _____ hours _____ minutes

The child's usual bedtime on **weekend/vacation nights:** _____:_____

The child's usual waking time on **weekend/vacation mornings**: _____:_____

Nap Schedule

Number of days each week child takes a nap: · 0 · 1 · 2 · 3 · 4 · 5 · 6 · 7

If child naps, write in usual nap time(S):

Nap 1: ____ : ____ · a.m. · p.m. to ____ : ____ · a.m. · p.m.

Nap 2: ____ : ____ · a.m. · p.m. to ____ : ____ · a.m. · p.m.

General Sleep			
Does the child have a regular bedtime routine?	· yes · no		
Does the child have his/her own bedroom?	· yes · no		
Does the child have his/her own bed?	· yes · no		
Is a parent present when your child falls asleep?	· yes · no		
Child usually **falls asleep in**… · own room in own bed (alone) · parents' room in own bed · parents' room in parents' bed · sibling's room in own bed · sibling's room in sibling's bed	Child **sleeps most of the night in**… · own room in own bed (alone) · parents' room in own bed · parents' room in parents' bed · sibling's room in own bed · sibling's room in sibling's bed	Child usually **wakes in the morning in**… · own room in own bed (alone) · parents' room in own bed · parents' room in parents' bed · sibling's room in own bed · sibling's room in sibling's bed	
Child is usually put to bed by: · Mother · Father · Both Parents · Self · Others			
Write in the <u>amount of time</u> the child spends in <u>his/her bedroom</u> before going to sleep: _____ minutes			
Child resists going to bed? · yes · no	**If yes**, do you think this is a problem? · yes · no		
Child has difficulty falling asleep? · yes · no	**If yes**, do you think this is a problem? · yes · no		
Child awakens during the night? · yes · no	**If yes**, do you think this is a problem? · yes · no		

After nighttime awakening, child has difficulty falling back to sleep?	· yes · no	**If yes**, do you think this is a problem?	· yes · no
Child is difficult to awaken in the morning?	· yes · no	**If yes**, do you think this is a problem?	· yes · no
Child is a poor sleeper?	· yes · no	**If yes**, do you think this is a problem?	· yes · no
Child refreshed in the morning?	· yes · no		
Childs sleeping area cool, dark and quiet?	· yes · no		
Child bothered by outside lights, noise, people, animals when trying to sleep?	· yes · no		
Child watches TV or uses electronic devices (computer, tablets, phones, etc.) before bed?	· yes · no		
Child complains of mind racing, being worried or depressed when awake at night?	· yes · no		
Child sleeps in the following positions:	· Back · Side · Stomach		

Current Sleep Symptoms							
							(f) do not know
						(e) always (6 to 7 nights/days a week)	
					(d) often (3 to 5 nights/days a week)		
				(c) sometimes (1 to 2 nights/days a week)			
			(b) not often (less than 1 night/day a week)				
			(a) never (does not happen)				
1.	Difficulty breathing when asleep	a	b	c	d	e	f
2.	Stops breathing during sleep	a	b	c	d	e	f
3.	Snores	a	b	c	d	e	f
4.	Chokes or gasps at night	a	b	c	d	e	f
5.	Breathes mainly through mouth at night	a	b	c	d	e	f
6.	Significant nasal congestion at night	a	b	c	d	e	f
7.	Has known reflux at night or awakens with bad taste in mouth as if acid has come up	a	b	c	d	e	f
8.	Sweating when sleeping	a	b	c	d	e	f
9.	Complains of a headache upon awakening	a	b	c	d	e	f
10.	Restless sleep; tosses and turns when asleep	a	b	c	d	e	f
11.	Uncomfortable feeling in his/her legs; creepy-crawly feeling when trying to go to sleep	a	b	c	d	e	f
12	Kicks legs in sleep	a	b	c	d	e	f
13.	Sleepwalking	a	b	c	d	e	f
14.	Sleep talking	a	b	c	d	e	f
15.	Night terrors	a	b	c	d	e	f
16.	Nightmares Screaming in his/her sleep	a	b	c	d	e	f
17.	Wets bed in sleep	a	b	c	d	e	f
18.	Trouble staying in his/her bed	a	b	c	d	e	f
19.	Resists going to bed at bedtime	a	b	c	d	e	f
20.	Grinds his/her teeth	a	b	c	d	e	f
21.	Wakes up at night	a	b	c	d	e	f
22.	Gets out of bed at night	a	b	c	d	e	f

Current Daytime Symptoms							
							(f) do not know
						(e) always (6 to 7 days a week)	
					(d) often (3 to 5 days a week)		
				(c) sometimes (1 to 2 days a week)			
			(b) not often (less than 1 day a week)				
		(a) never (does not happen)					
1.	Trouble getting up in the morning	a	b	c	d	e	f
2.	Falls asleep in school	a	b	c	d	e	f
3.	Naps after school	a	b	c	d	e	f
4.	Daytime sleepiness	a	b	c	d	e	f
5.	Feels weak or loses control of his/her muscles with strong emotions	a	b	c	d	e	f
6.	Reports unable to move when falling asleep or upon waking	a	b	c	d	e	f
7.	Sees frightening visual images before falling asleep or upon waking	a	b	c	d	e	f

PREGNANCY/ DELIVERY			
Pregnancy	✹ Normal	✹ Difficult	
Delivery	✹ Term	✹ Pre-term ✹ Post-term	
Child's birthweight:			
Only child?	✹ Yes	✹ No	If no, circle birth order: 1st 2nd 3rd 4th 5th 6th 7th

MEDICAL AND PSYCHIATRIC HISTORY

PAST MEDICAL HISTORY			
Frequent nasal congestion	✹ Yes	Age of diagnosis:	
Trouble breathing through his/her nose	✹ Yes	Age of diagnosis:	
Sinus problems	✹ Yes	Age of diagnosis:	
Chronic bronchitis or cough	✹ Yes	Age of diagnosis:	
Allergies	✹ Yes	Age of diagnosis:	Allergic to what:
Asthma	✹ Yes	Age of diagnosis:	

MEDICAL AND PSYCHIATRIC HISTORY

PAST MEDICAL HISTORY

Frequent colds or flus	✹ Yes	Age of diagnosis:
History of enlarged tonsils or adenoids	✹ Yes	Age of diagnosis:
Frequent ear infections	✹ Yes	Age of diagnosis:
Frequent strep throat infections	✹ Yes	Age of diagnosis:
Difficulty swallowing	✹ Yes	Age of diagnosis:
Acid reflux (gastroesophageal reflux)	✹ Yes	Age of diagnosis:
Poor or delayed growth	✹ Yes	Age of diagnosis:
Excessive weight	✹ Yes	Age of diagnosis:
Hearing problems	✹ Yes	Age of diagnosis:
Speech problems	✹ Yes	Age of diagnosis:
Vision problems	✹ Yes	Age of diagnosis:
Seizures/Epilepsy	✹ Yes	Age of diagnosis:
Morning headaches	✹ Yes	Age of diagnosis:
Cerebral palsy	✹ Yes	Age of diagnosis:
Heart disease	✹ Yes	Age of diagnosis:
High blood pressure	✹ Yes	Age of diagnosis:
Sickle cell disease	✹ Yes	Age of diagnosis:
Genetic disease	✹ Yes	Age of diagnosis:
Chromosome problem (e.g., Down's)	✹ Yes	Age of diagnosis:
Skeleton problem (e.g., dwarfism)	✹ Yes	Age of diagnosis:
Cranofacial disorder (e.g., PierreRobin)	✹ Yes	Age of diagnosis:
Thyroid problems	✹ Yes	Age of diagnosis:
Eczema (itchy skin)	✹ Yes	Age of diagnosis:
Pain	✹ Yes	Age of diagnosis:

PAST PSYCHIATRIC/PSYCHOLOGICAL HISTORY		
Autism	✹ Yes	Age of diagnosis:
Developmental delay	✹ Yes	Age of diagnosis:
Hyperactivity/ADHD	✹ Yes	Age of diagnosis:
Anxiety/Panic Attacks	✹ Yes	Age of diagnosis:
Obsessive Compulsive Disorder	✹ Yes	Age of diagnosis:
Depression	✹ Yes	Age of diagnosis:
Suicide	✹ Yes	Age of diagnosis:
Learning disability	✹ Yes	Age of diagnosis:
Drug use/abuse	✹ Yes	Age of diagnosis:
Behavioral disorder	✹ Yes	Age of diagnosis:
Psychiatric Admission	✹ Yes	Age of diagnosis:
Please list any additional psychological, psychiatric, emotional, or behavioral problems diagnosed or suspected by a physician/psychologist/ or concerns brought to you by teachers.		

CURRENT MEDICAL HISTORY		
Please list any medications your child currently takes:		
Medicine	Dose	How often?
1.		
2.		
3.		
4.		
Is your child allergic to any medications? If yes, please list here:		

LONG-TERM MEDICAL PROBLEMS

If your child has long-term medical problems, please list the three you think are most important.

1.

2.

3.

SURGERIES/HOSPITALIZATIONS

Has your child ever had his/her tonsils removed?	✹ Yes	Age of surgery:
Has your child ever had his/her adenoids removed?	✹ Yes	Age of surgery:
Has your child ever had ear tubes?	✹ Yes	Age of surgery:

Please list any additional hospitalizations or surgeries:

HEALTH HABITS

Does your child drink caffeinated beverages? (e.g., Coke, Pepsi, Mountain Dew, iced tea)	✹ Yes ✹ No	Amount per day:

FAMILY SLEEP HISTORY				
Does anyone in the family have a sleep disorder?	✹ Yes	✹ No		
If yes, mark the disorder(s):				
Insomnia	✹ Mother	✹ Father	✹ Brother/sister	✹ Grandparent
Snoring	✹ Mother	✹ Father	✹ Brother/sister	✹ Grandparent
Sleep apnea	✹ Mother	✹ Father	✹ Brother/sister	✹ Grandparent
Restless legs syndrome	✹ Mother	✹ Father	✹ Brother/sister	✹ Grandparent
Periodic limb movement disorder	✹ Mother	✹ Father	✹ Brother/sister	✹ Grandparent
Sleepwalking/sleep terrors	✹ Mother	✹ Father	✹ Brother/sister	✹ Grandparent
Sleep talking	✹ Mother	✹ Father	✹ Brother/sister	✹ Grandparent
Narcolepsy	✹ Mother	✹ Father	✹ Brother/sister	✹ Grandparent
Other:	✹ Mother	✹ Father	✹ Brother/sister	✹ Grandparent

Adapted by Gregory L. Clark M.D.,Ph.D. 03/06/2016 from:

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