St. Charles Hospital
Catholic Health Services
At the heart of health

Pediatric Patient

ST CHARLES HOSPITAL SLEEP DISORDERS CENTER
SLEEP QUESTIONNAIRE FOR PEDIATRIC PATIENTS

PATIENT INFORMATION

PATIENT NAME_____ ☐ Male ☐ Female

ADDRESS_____

DATE OF BIRTH_____ AGE_____ SOCIAL SECURITY #_____

HOME TELEPHONE # ( )_____ CELL PHONE # ( )_____

NAME OF PERSON COMPLETING QUESTIONNAIRE_____

EMAIL OF PERSON COMPLETING QUESTIONNAIRE _____

EMERGENCY CONTACT PERSON _____

RELATIONSHIP TO PATIENT_____

ADDRESS_____TELEPHONE # ( )_____

PHYSICIAN
PRIMARY CARE PHYSICIAN_____
ADDRESS_____
TELEPHONE #_____ FAX #_____

PRIMARY MEDICAL INSURANCE
INSURANCE COMPANY_____
TELEPHONE # (ON BACK OF CARD)_____
ID #_____ GROUP #_____
PLAN#_____
POLICY HOLDER'S NAME_____

AMERICAN ACADEMY OF SLEEP MEDICINE
WAKE SLEEP
ACCREDITED
MEMBER CENTER

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ADDRESS_____
TELEPHONE #_____
SOCIAL SECURITY #_____DATE OF BIRTH_____
RELATIONSHIP TO PATIENT_____

POLICY HOLDER'S EMPLOYER
EMPLOYER NAME_____
ADDRESS_____
TELEPHONE #_____HOURS/DAYS_____

SECONDARY MEDICAL INSURANCE
INSURANCE COMPANY_____
TELEPHONE # (ON BACK OF CARD)_____
ID #_____ GROUP #_____
PLAN#_____
POLICY HOLDER'S NAME_____
ADDRESS_____
TELEPHONE #_____
SOCIAL SECURITY #_____DATE OF BIRTH_____
RELATIONSHIP TO PATIENT_____

POLICY HOLDER'S EMPLOYER
EMPLOYER NAME_____
ADDRESS_____
TELEPHONE #_____HOURS/DAYS_____

ELECTRONIC SCRIPT INFORMATION (AS REQUIRED BY NYS)

PHARMACY NAME_____

PHARMACY ADDRESS_____

PHARMACY TELEPHONE#_____

PHARMACY FAX#_____

GENERAL PHYSICAL INFORMATION

HEIGHT_____ WEIGHT_____ SHIRT COLLAR SIZE_____INCHES

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DO YOU CURRENTLY UTILIZE OXYGEN DURING SLEEP? ☐YES ☐NO
IF YES, HOW LONG HAVE YOU BEEN USING IT?_____ LITER FLOW_____

DO YOU CURRENTLY UTILIZE NASAL CPAP OR BIPAP DURING SLEEP?
☐YES ☐NO

Will patient require medical equipment overnight?

_____

If medical equipment is required, please list what type:_____

_____

_____

BEHAVIORS IN SLEEP

BED WETTING

1. Does your child ever wet the bed (if already toilet trained)?☐YES ☐NO

2. How long has the bedwetting occurred?_____ Years_____Months

3. How often does your child wet the bed?
   - ☐Every night
   - ☐2-3 times per week
   - ☐once a week
   - ☐several times a month
   - ☐once a month
   - ☐less than once a month

Check any of the following behaviors that you have observed your child doing **while asleep**:

- ❑ Loud snoring

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- ❑ Light snoring
- ❑ Restless sleeper
- ❑ Twitching of legs or feet
- ❑ Pauses in breathing
- ❑ Waking up choking, smothering or gasping for air
- ❑ Has frightening dreams
- ❑ Grinding teeth
- ❑ Sleep talking
- ❑ Sleepwalking
- ❑ Bedwetting
- ❑ Sitting up in bed while still asleep
- ❑ Head rocking or banging
- ❑ Kicking with legs
- ❑ Getting out of bed while still asleep
- ❑ Biting tongue
- ❑ Becoming very rigid and/or shaking

DAYTIME SLEEPINESS

	YES	NO
1. Is your child sleepy during the day?	☐	☐
2. How long has your child been sleepy?	_____	
3. Does your child doze during the day?	☐	☐
4. Does your child fall asleep in school?	☐	☐
5. Does your child fall asleep at unusual times (e.g., meals, watching tv)?	☐	☐
6. Does your child take spontaneous naps?	☐	☐
How many days per week?	_____	

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How many times per day? _____

What time(s) of day do naps occur? _____

How long are the naps? _____

MOTHER'S PREGNANCY

1. Total number of pregnancies_____

2. Total number of live-born children_____

3. Mother's age at time of child's birth_____

4. Birth weight_____

5. Any problems during pregnancy, labor, or delivery? ☐YES ☐NO
   If yes, please explain

6. Was your child a vaginal delivery or C-section?_____

   If C-section, why? _____

_____

7. Was your child discharged from the hospital with you when he/she was born?
   ☐YES ☐NO

   If no, please explain. _____

_____

_____

_____

8. Was your child breast fed or formula?_____

   If breast fed, how long?_____

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DEVELOPMENT

List age in months when skill attained:

Smile	_____
Roll over	_____
Sit without support	_____
Crawl	_____
Walk unassisted	_____
First word	_____
First sentence	_____
Complete toilet training	_____
Tie shoelaces	_____
Ride bicycle	_____

HEALTH HISTORY

List all surgical procedures and hospitalizations

	Age
_____	_____
_____	_____
_____	_____
_____	_____

List any major health or behavior problems

	Age
_____	_____
_____	_____
_____	_____

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_____ _____

_____ _____

_____ _____

_____ _____

MEDICATIONS

Medication	Dose	Frequency
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Does your child:

1. Drink caffeinated soda? ☐YES ☐NO How much?_____

2. Drink other caffeinated beverages? ☐YES ☐NO How much?_____

ALLERGIES

Does your child have any allergies to medications and/or latex? ☐YES ☐NO

If yes, please list_____

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Does your child have any allergies to food? ☐YES ☐NO

If yes, please list_____

Does your child have eczema? ☐YES ☐NO

Have asthma or wheezing? ☐YES ☐NO

FAMILY HISTORY

Current marital status of parents: ☐Married ☐Divorced ☐Separated ☐Other

Mother: Name_____

Age/Date of Birth_____

Highest grade or degree completed_____

Occupation_____

Currently working? ☐YES ☐NO

Any sleep problems? ☐YES ☐NO

Father: Name_____

Age/Date of Birth_____

Highest grade or degree completed_____

Occupation_____

Currently working? ☐YES ☐NO

Any sleep problems? ☐YES ☐NO

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Siblings

Name	Age
_____	_____
_____	_____
_____	_____
_____	_____

Other people living in household

Name	Age
_____	_____
_____	_____
_____	_____
_____	_____

Are there any pets in the household?

If yes: How many? _____

What type? _____

SCHOOL

1. Current grade in school_____
2. Type of class

   ☐Regular class
   ☐Learning disability
   ☐Other

3. School performance

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☐above average
☐average
☐below average