SLEEP DIAGNOSTIC SERVICES
Sleep. Health. Life.

Pediatric Sleep Laboratory

Please fill out this questionnaire and bring with you to your appointment.

Date:_____________ Date of study:________________

Patient Name:_________________________________ DOB:_________________

Address:____

Parent's Name who will attend the study:_______________________________________

Phone:__________________ Cell:___________________

Work:_____________________

Referring Doctor:______________________ Phone #:______________________

Family Doctor or Pediatrician:____________________ Phone #:____________________

Current Sleep Problems:____

____

Please Answer YES or NO

Does your child exhibit any of the following?

Snore:_________ (Loudly:________ Continuously:__________)

Have noisy breathing:________________ Change color:____________

Have frequent sinus problems:_______________ Choke:____________

Have breathing problems upon awakening:_______________ Turn pale:_____________

Become congested:____________ Turn blue:____________

Have frequent colds:_____________ Stop Breathing:_______________

Cough or wheeze at night:_______________ Gasp for air:_________________

Have a tracheotomy:______________ Have GI reflux:_____________

Receive oxygen therapy:_______________ Currently on CPAP:____________

Require special treatment (suction, aerosol treatments, etc.):______________

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Does your child exhibit any of the following Sleep or Health Problems?

Attention problems:__________ Bedwetting:______________

Frightening dreams:______________ Night Terrors:___________

Tooth grinding:_______________ Head banging:_____________

Humming while falling asleep:____________ Body rocking:_____________

Sleepy during the day:_____________ Night sweats:________________

Difficulty falling asleep:_____________ Stomach pain:______________

Hyperactivity:___________ Awakens during the night:_____________

Daytime Behavioral problems:______________ Leg pains:______________

Very emotional or anxious:______________ Overweight:___________

Falls asleep at school:___________ Falls asleep at inappropriate times:_________

Sleeps through the night:__________

If you answered YES to any of the above questions, please elaborate where necessary. Use the back side of this page if needed:____

____

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Sleeping information:

What time does your child typically:

Go to sleep- Weekdays:_______________ Weekends:________________

Awaken- Weekdays:__________________ Weekends:_______________

Naps- Lengths:_______________ Number per day:____________

Does your child typically:

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:______________

Medical History:

Height:______________ Weight:______________ (Please approximate if unknown)

Any previous hospitalizations and/or surgeries? (If yes, please specify when and where):
____

____

____

Any past diagnoses? ____

____

Tonsil and Adenoid Removal? (If yes, please specify when and where):
____

____

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Current Medications: (Please list all prescription, over-the-counter medications and vitamins)

Medication	Dosage	Frequency	Prescribing Physician?	Date Began

Discontinued Medications: (Within the last 6 months)

Medication	Dosage	Frequency	Prescribing Physician?	Date Discontinued

Family History: (If YES, please date approximate diagnosis or occurrence)

	Mother	Father
Age		
Sleep Disorder		
Asthma/Lung Disease		
Allergies (Medicine, Latex, Etc.)		
Other Additional Information		

	Sibling	Sibling
Age/Gender		
Sleep Disorder		
Asthma/Lung Disease		
Allergies (Medicine, Latex, Etc.)		
Other Additional Information		