WMED HEALTH

THE CLINICAL PRACTICE OF WESTERN MICHIGAN UNIVERSITY
HOMER STRYKER M.D. SCHOOL OF MEDICINE

PEDIATRIC SLEEP QUESTIONNAIRE

This set of questions is designed to help understand your child's sleep patterns and any sleep-related problems. Please take the time to answer them and bring the questionnaire to your next appointment.

Part 1 – Patient Information

Male Female

Name _____ Age _____ Date of Birth _____
Home Phone _____ Work Phone _____ Today's date _____
Physicians caring for your child (family doctor, specialists, psychologist, etc.) _____
_____

Part 2 – Main Complaint

What is your child's main sleep or alertness complaint? _____
How long has it occurred? _____
Has your child ever had a sleep study? Please indicate when and where. _____

Part 3 – Before Bedtime

What does your child do before bedtime? _____
_____
Is there a set routine or does it change from day to day? _____
Does your child do things that could be exciting or frightening before bedtime such as watch TV, play video games or talk to friends on the phone?
_____

Part 4 – Falling Asleep

Where does your child usually fall asleep? Does this vary? _____
_____
Does your child share a bedroom?
Are there any distractions in the bedroom such as noises or lights that might affect sleep? _____
_____
When is bedtime? _____ How long does it take to fall asleep usually? _____
Does your child have any habits about falling asleep such as rocking or head banging? Yes No

Part 5 – Sleeping

Does your child do anything unusual or worrisome during sleep?
If so, please describe. _____
_____
_____

Please indicate if your child does any of the following after falling asleep.

Talk	Grind teeth	Perspire excessively	Walk
Bedwetting	Sleep restlessly	Sleep in unusual positions	Twitch or jerk

Part 6 – Nighttime Awakenings and Arousals

Does your child have frequent nightmares? Yes No
Does your child awaken to use the toilet most nights? Yes No
Does your child get leg pains, growing pains or cramps? Yes No
Does your child awaken during the night? Yes No
If yes, how may nights weekly and how often each night? _____
What usually awakens your child, if anything? _____

Part 7 – Breathing-Related Problems

Have you ever been worried about your child's breathing during sleep? Yes No
Does your child snore on most night? Yes No If so, how loudly? _____
Does your child do any of the following during sleep?
Gasp Choke Drool Stop breathing Cough
Is your child usually a mouth breather during the day or the night? Day Night
Does your child often awaken with a dry mouth or sore throat? Yes No
Is your child comfortable sleeping on his or her back? Yes No
Does your child sleep on more than one pillow or sitting up? Yes No

Part 8 – Morning Awakening

What time does your child usually awaken on weekdays? _____Weekends _____
How difficult is it to awaken your child? _____
How late would your child like to sleep if not disturbed?_____
How long after awakening, before your child is fully alert?_____
Does your child frequently awaken with headaches? Yes No

Part 9 – Daytime

Is your child sleepy during the day? Yes No
If so, how long has this been going on? _____
Does he or she take naps? Yes No
If so, when and how long?_____
Does your child sleep in inappropriate times? Yes No
Does your child have episodes of unexplained pain or crying? Yes No
Does your child spit up, vomit or have heartburn? Yes No
Does your child have trouble maintaining attention? Yes No
Is your child moody or irritable? Yes No
Would you consider your child to be more than other children? Nervous Anxious Perfectionist
Does your child drink beverages with caffeine? Yes No
(Tea, coffee, cola, Mountain Dew or Dr. Pepper) if so, when and how much? _____
_____

Section 10 – Parasomnias

Does your child ever experience waking with the feeling of complete paralysis briefly? Yes No

Does your child have brief attacks of muscle weakness or falls for no clear reason? Yes No

Does your child ever hallucinate sights or sounds while falling asleep as if dreams are beginning before her she is fully asleep? Yes No

Part 11 – Medications

Please list all the current medications, vitamins, herbal supplements, and oxygen you child uses.

_____

_____

_____

_____

_____

_____

_____

_____

_____

Part 12 –Operations

Please list all the surgeries and what year.

_____

_____

_____

_____

_____

_____

_____

_____

_____

Part 13 – Illnesses and Injuries

Please list all the medical conditions and serious injuries.

_____

_____

_____

_____

_____

Part 14 – Allergies

Yes No

If yes, please list them.

_____

_____

_____

_____

_____

Part 15 – Pregnancy, Labor and Delivery

During the pregnancy did mother use:

Tobacco
Alcohol
Medications_____
Recreational Drugs

Was the child born on time? Yes No

What was the birth weight?_____

Please note any other problems during pregnancy or delivery

_____

_____

_____

_____

_____

Part 16 – Family History

Please list medical conditions in blood relatives (parents, siblings, grandparents, etc. and whom the relative is (ie: high blood pressure, stroke, heart attack, and diabetes.)

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Are there any sleep-related disorders in the family? ☐ Yes ☐ No

Part 17 – Review of Systems

Do you have any problems relating to

☐ Shortness of breath	☐Fatigue	☐Difficulty with concentration
☐ Palpitations	☐Chest pain	☐Intolerance to heat or cold
☐Nose bleeds	☐Congestion	☐Abdominal distention/bloating
☐Rash	☐Headaches	☐New food allergies

Part 18 – Social History

What grade is your child in if applicable?_____

Number of siblings_____

Who lives at home?_____

Activities outside of school and home_____

Part 19 – Addition Information

Is there anything else that you feel may be important for the physician to know about your child's sleep and
alertness problems or health?

_____

_____