BEACON HEALTH SYSTEM

Patient Label

Pediatric Sleep Evaluation Questionnaire

This questionnaire has been compiled in order to best assist us in assessing our pediatric patient's sleep. Please complete all questions to the best of your knowledge. The information provided will become a part of the medical record and is strictly confidential.

Demographics

Patient's Name (Last, First):_______________________ Date of Birth: ____ /____ /________

Height: __________(cm) Weight: __________(kg) Race: ______________________ Gender: ☐ M ☐ F

Questionnaire filled out by: ______________________ Relationship to Patient: ______________________

Primary Care Physician: ______________________ Referring Physician: ______________________

ENT Physician (if other than referring): ______________________

Sleep Problems

What are your major concerns about your child's sleep? Please CHECK ALL that apply and **PLACE A STAR NEXT TO YOUR MAIN CONCERN**.

- ☐ Breathing problem during sleep (e.g. snoring, choking, gasping, not breathing)
- ☐ Unusual episodes at night (e.g. sleepwalking, sleep talking, nightmares, night terrors)
- ☐ Restless during sleep
- ☐ Leg pain or discomfort before bed
- ☐ Problems consistently getting enough sleep
- ☐ Problems falling or staying asleep
- ☐ Feeling tired or sleepy during the day
- ☐ Other (Please describe): ______________________

____

Child's Medical History

Does your child have a history of any of the following? *(*Place a check mark if applicable)*

- ☐ Trouble breathing through nose
- ☐ Frequent nasal congestion
- ☐ Allergies
- ☐ Asthma
- ☐ Chronic bronchitis or recurrent cough
- ☐ Recurrent respiratory illness
- ☐ Poor or delayed growth
- ☐ Excessive weight
- ☐ Anxiety or worries
- ☐ Hyperactivity / ADHD
- ☐ Behavioral disorder
- ☐ Others: ______________________

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- ☐ Morning headaches
- ☐ Seizures/Epilepsy
- ☐ Thyroid problems
- ☐ Heart disease
- ☐ High blood pressure
- ☐ Sickle cell disease
- ☐ Developmental delay
- ☐ Cerebral palsy
- ☐ Skeleton problems
- ☐ Craniofacial disorder (e.g., Pierre-Robin)
- ☐ Chromosome problem (e.g., Down's)

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Past Surgical History

Has your child ever had his/her tonsils removed? ☐ Yes What age? ________

Has your child ever had his/her adenoids removed? ☐ Yes What age? ________

Has your child ever had any other surgeries? ☐ Yes

Describe below (include age when surgery was performed):

____

____

Medications

Please list the medications that your child takes on a regular basis.

Medicine Name	Dose	Frequency taken
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

Please provide any other information that you feel is necessary for the doctor reading the sleep study:

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