Bluewater
SLEEP DISORDER CLINIC

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Pediatric Sleep Questionnaire

Patient name_____ DOB:_____

Weight : _____ Height: _____

Please mark (✓) if you experience any of the following symptoms:

	Snoring		Teeth grinding
	Stop breathing during sleep		Bedwetting
	Daytime sleepiness		Restless leg syndrome
	Morning headaches		Vivid dreams
	Mouth breathing		Sleep paralysis
	Sleepwalking		Acting out dreams
	Sleep talking		Muscular weakness triggered by emotion
	Complex behaviours during sleep		Previously diagnosed sleep apnea

Sleep Schedule

Bedtime_____ am/pm (weekdays) and _____ am/pm (weekends)

Wake time _____ am/pm (weekdays) and _____ am/pm (weekends)

Do you sleep in your own room? _____How long does it take for you to fall asleep? _____

Number of times you wake up per night? _____

How long does it take you to fall back asleep? _____

Do you take naps? _____Do you fall asleep at school?_____

Do you use electronics at night? _____For how long?_____

_____

Past Medical History: _____

Past Surgical History: _____

Medications : _____

Allergies: _____ Do you have pets at home? Y/N _____

Birth History:_____

Developmental milestones on time? Y/N? if no, please explain_____

_____

Family History:_____

School Grade & Performance: _____

Special Needs?_____

Do you use Caffeine products?_____ Alcohol? _____tobacco? _____

Recreational drugs?_____

Sleepiness Scale

Over the past month, how likely have you been to fall asleep while doing the things that are described below (activities)? Even if you haven't done some of these things in the past month, try to imagine how they would have affected you.

Use the following scale to circle the number that best describes what has been happening to you during each activity over the past month.

0 would ***never*** fall asleep

1 ***Slight*** chance of falling asleep

2 ***Moderate*** chance of falling asleep

3 ***High*** chance of falling asleep

ACTIVITY	**CHANCE OF FALLING ASLEEP**
Sitting and reading	0 1 2 3
Sitting and watching TV or Video	0 1 2 3
Sitting in the classroom at school during the morning	0 1 2 3
Sitting and riding in a car or a bus for about a half an hour	0 1 2 3
Lying down to rest in the afternoon	0 1 2 3
Sitting and talking to someone	0 1 2 3
Sitting quietly by yourself after lunch	0 1 2 3
Sitting and eating a meal	0 1 2 3
TOTAL SCORE:	