Sutter Health
Palo Alto Medical Foundation

Pediatrics Sleep Wake Questionnaire

This questionnaire is for patients 12 years of age or younger who have a **scheduled appointment** at the Sleep Center. It will take approximately 15 to 20 minutes to complete. The information you provide is **very** important and will assist the sleep specialist during the review of your sleep symptoms. This questionnaire has been compiled based on many years of accumulated experience in Sleep Medicine. The information will be treated with the utmost discretion and will not be used by any party other than Palo Alto Medical Foundation. Please respond to all questions by checking the appropriate box or completing the free text sections. If you have a bed partner, a parent or guardian or someone who is willing and able to comment on your sleep patterns or behaviors during sleep, please have them complete Section 11.

_____
Child's Name

_____ _____
Scheduled Appointment Date Sleep Specialist

_____ _____ _____ _____
Today's Date DOB Age Sex

_____ _____
Height (inches) Weight Now (lbs)

_____ _____
Your child was referred by? Name of Doctor

What are your concerns or issues about your child's sleep?

1. _____

What have you tried to help with your child's sleep problems?

2. _____

1. Sleep Schedule

How much sleep does your child get on an average night during weekdays (hours)? _____

What time does your child go to bed on **weekdays**? _____ ☐ a.m. ☐ p.m.

What time does you child get out of bed on **weekdays**? _____ ☐ a.m. ☐ p.m.

How much sleep does your child get on an average night during weekends (hours)? _____

What time does your child go to bed on **weekdays**? _____ ☐ a.m. ☐ p.m.

What time does your child get out of bed on **weekends**? _____ ☐ a.m. ☐ p.m.

Does your child nap on **weekdays**? ☐ Yes ☐ No

If **yes**, how many days each week does you child take a nap? _____

What are the usual nap times? (**from** (a.m./p.m.) **to** (a.m./p.m.)) _____

Does your child nap on **weekends**? ☐ Yes ☐ No

What are the usual nap times? (**from** (a.m./p.m.) **to** (a.m./p.m.)) _____

Does your child have a regular bedtime routine? ☐ Yes ☐ No

Does your child have their own bedroom? ☐ Yes ☐ No

Does your child have their own bed? ☐ Yes ☐ No

Is a parent present when the child falls asleep? ☐ Yes ☐ No

How long does your child spend in their bedroom before going to sleep? (minutes) _____

Does your child resist going to bed **most nights**? ☐ Yes ☐ No

If **yes**, do you think this is a problem? ☐ Yes ☐ No

Does your child have difficulty falling asleep **most nights**? ☐ Yes ☐ No

If **yes**, do you think this is a problem? ☐ Yes ☐ No

Does your child awaken during the night on **most nights**? ☐ Yes ☐ No

If **yes**, do you think this is a problem? ☐ Yes ☐ No

Does your child have trouble falling back to sleep after awakening during the night? ☐ Yes ☐ No

If **yes**, do you think this is a problem? ☐ Yes ☐ No

Does your child have difficulty waking **most mornings**? ☐ Yes ☐ No

If **yes**, do you think this is a problem? ☐ Yes ☐ No

Do you think your child is a poor sleeper **most nights**? ☐ Yes ☐ No

If **yes**, do you think this is a problem? ☐ Yes ☐ No

Who is your child usually put to bed by?

☐ Mother ☐ Father ☐ Both Parents ☐ Sibling ☐ Other

Where does your child usually **fall asleep**?

☐ Their own room in their own bed.
☐ Parent's room in parent's bed.
☐ Living room or TV room (not a bedroom).
☐ Sibling's room in sibling's bed.
☐ Other

Where does your child sleep through **most of the night**?

☐ Their own room in their own bed.
☐ Parent's room in parent's bed.
☐ Living room or TV room (not a bedroom).
☐ Sibling's room in sibling's bed.
☐ Other

Where does your child usually wake in the **morning**?

☐ Their own room in their own bed.
☐ Parent's room in parent's bed.
☐ Living room or TV room (not a bedroom).
☐ Sibling's room in sibling's bed.
☐ Other

2. Your Child's Current Nighttime Symptoms

Have you witnessed, or has your child ever mentioned experiencing any of the following?

Difficulty breathing when asleep	☐ Yes	☐ No	☐ Don't Know
Stops breathing during sleep	☐ Yes	☐ No	☐ Don't Know
Snores	☐ Yes	☐ No	☐ Don't Know

Restless sleep	☐ Yes	☐ No	☐ Don't Know
Nighttime sweating	☐ Yes	☐ No	☐ Don't Know
Nightmares	☐ Yes	☐ No	☐ Don't Know
Sleepwalking	☐ Yes	☐ No	☐ Don't Know
Sleep talking	☐ Yes	☐ No	☐ Don't Know
Screaming/yelling in their sleep	☐ Yes	☐ No	☐ Don't Know
Kicks legs in sleep	☐ Yes	☐ No	☐ Don't Know
Gets out of bed at night	☐ Yes	☐ No	☐ Don't Know
Trouble staying in bed	☐ Yes	☐ No	☐ Don't Know
Wakes up at night	☐ Yes	☐ No	☐ Don't Know
Resists going to bed at bedtime	☐ Yes	☐ No	☐ Don't Know
Grinds teeth when sleeping	☐ Yes	☐ No	☐ Don't Know
Uncomfortable feelings in legs	☐ Yes	☐ No	☐ Don't Know
Wets bed	☐ Yes	☐ No	☐ Don't Know

3. Your Child's Current Daytime Symptoms

Have you witnessed, or has your child ever mentioned experiencing any of the following?

Trouble getting up in the morning	☐ Yes	☐ No	☐ Don't Know
Falls asleep in school	☐ Yes	☐ No	☐ Don't Know
Falls asleep after school	☐ Yes	☐ No	☐ Don't Know
Daytime sleepiness	☐ Yes	☐ No	☐ Don't Know
Feels weak or loses control during strong emotions (laughing, excited, during a tantrum)	☐ Yes	☐ No	☐ Don't Know
Reports they are unable to move when falling asleep or when waking	☐ Yes	☐ No	☐ Don't Know

Sees frightening visual images before falling asleep or when waking	☐ Yes	☐ No	☐ Don't Know
Poor appetite	☐ Yes	☐ No	☐ Don't Know

4. Pregnancy / Delivery

Was the pregnancy	☐ Normal	☐ Difficult	☐ Don't Know	
Was the child's delivery	☐ Pre-term	☐ Term	☐ Post-term	☐ Don't Know
What was your child's birth weight?			_____	
Is your child an only child?	☐ Yes	☐ No		
If **no**, what is the child's birth order (1st, 2nd, 3rd...do no know)?			_____	

5. Your Child's Past Medical History

Frequent Nasal Congestion	☐ Yes	☐ No	Age at diagnosis: _____
Trouble Breathing Through Nose	☐ Yes	☐ No	Age at diagnosis: _____
Sinus Problems	☐ Yes	☐ No	Age at diagnosis: _____
Chronic Bronchitis	☐ Yes	☐ No	Age at diagnosis: _____
Asthma	☐ Yes	☐ No	Age at diagnosis: _____
Frequent Cold Or Flu	☐ Yes	☐ No	Age at diagnosis: _____
Frequent Ear Infections	☐ Yes	☐ No	Age at diagnosis: _____
Frequent Strep Throat	☐ Yes	☐ No	Age at diagnosis: _____
Difficulty Swallowing	☐ Yes	☐ No	Age at diagnosis: _____
Acid Reflux	☐ Yes	☐ No	Age at diagnosis: _____
Poor Or Delayed Growth	☐ Yes	☐ No	Age at diagnosis: _____
Excess Weight	☐ Yes	☐ No	Age at diagnosis: _____
Hearing Problems	☐ Yes	☐ No	Age at diagnosis: _____

Speech Problems	☐ Yes	☐ No	Age at diagnosis: _____
Vision Problems	☐ Yes	☐ No	Age at diagnosis: _____
Seizures/Epilepsy	☐ Yes	☐ No	Age at diagnosis: _____
Morning Headaches	☐ Yes	☐ No	Age at diagnosis: _____
Cerebral Palsy	☐ Yes	☐ No	Age at diagnosis: _____
Heart Disease	☐ Yes	☐ No	Age at diagnosis: _____
High Blood Pressure	☐ Yes	☐ No	Age at diagnosis: _____
Genetic / Congenital Disease (Down's, Dwarfism, Pierre-Robin)	☐ Yes	☐ No	Age at diagnosis: _____
Thyroid Problems	☐ Yes	☐ No	Age at diagnosis: _____
Eczema	☐ Yes	☐ No	Age at diagnosis: _____
Chronic Pain	☐ Yes	☐ No	Age at diagnosis: _____
Allergies	☐ Yes	☐ No	Age at diagnosis: _____

Please list any known medication or environmental allergies (pets, pollens, food, etc.):

Autism	☐ Yes	☐ No	Age at diagnosis: _____
Developmental Delay	☐ Yes	☐ No	Age at diagnosis: _____
Hyperactivity / ADD	☐ Yes	☐ No	Age at diagnosis: _____
Anxiety / Panic Attacks	☐ Yes	☐ No	Age at diagnosis: _____
Obsessive Compulsive Disorder	☐ Yes	☐ No	Age at diagnosis: _____
Depression	☐ Yes	☐ No	Age at diagnosis: _____
Learning Disability	☐ Yes	☐ No	Age at diagnosis: _____
Drug Use / Abuse	☐ Yes	☐ No	Age at diagnosis: _____

Psychiatric Admission ☐ Yes ☐ No Age at diagnosis: _____

Please list any additional long term health or behavioral problems:

_____

6. Current Medications

Medication: _____ Dose: _____ How often? _____

Medication: _____ Dose: _____ How often? _____

Medication: _____ Dose: _____ How often? _____

Medication: _____ Dose: _____ How often? _____

Medication: _____ Dose: _____ How often? _____

7. Procedural/Surgical History

Has your child ever had a sleep study? ☐ Yes ☐ No

If **yes**, when? _____

If **yes**, where? _____

Has your child ever had their tonsils or adenoids removed? ☐ Yes ☐ No

Has your child ever had sinus or nasal surgery? ☐ Yes ☐ No

Has your child ever had ear tubes? ☐ Yes ☐ No

Have you had dental surgery or orthodontics? ☐ Yes ☐ No

If **yes**, please describe:

Please list any additional hospitalizations or surgeries

8. Social History

Does your child drink caffeinated beverages (soda, iced tea, energy drinks)? ☐ Yes ☐ No

If **yes**, how many bottles/cans per day? _____

Does your child drink sports drinks (Gatorade, Powerade, Vitamin Water)? ☐ Yes ☐ No

If **yes**, how many bottles/cans per day? _____

Does your child exercise regularly? ☐ Yes ☐ No

If **yes**, how many days each week does your child exercise? _____

How many minutes each day does your child exercise? _____

Does your child play video games? ☐ Yes ☐ No

If **yes**, how many minutes each day does your child play? _____

When does your child usually play video games?
(**from** (a.m./p.m.) **to** (a.m./p.m.)) _____

9. School Performance

What is your child's current school grade? _____

Has your child ever repeated a school grade? ☐ Yes ☐ No

If **yes**, what grade(s)? _____

Is your child enrolled in any special education classes? ☐ Yes ☐ No

How many school days has your child **missed** so far this school year? _____

How many school days did your child miss last year? _____

How many school days has your child been **late** this school year? _____

How many school days was your child late last year? _____

Has your child missed school due to school-initiated disciplinary action? ☐ Yes ☐ No

What are your child's grades **this year**?

☐ Excellent ☐ Good ☐ Average ☐ Failing ☐ Poor

What were your child's grades **last year**?

☐ Excellent ☐ Good ☐ Average ☐ Failing ☐ Poor

Please continue on next page

10. Family History

Does any member of the child's family have any of the following?

Snoring or sleep apnea? ☐ Yes ☐ No

If **yes**, relationship _____

Narcolepsy? ☐ Yes ☐ No

If **yes**, relationship _____

Seizure disorder? ☐ Yes ☐ No

If **yes**, relationship _____

Depression? ☐ Yes ☐ No

If **yes**, relationship _____

Hypertension, heart disease, heart failure? ☐ Yes ☐ No

If **yes**, relationship _____

Stroke? ☐ Yes ☐ No

If **yes**, relationship _____

Diabetes? ☐ Yes ☐ No

If **yes**, relationship _____

Name of person completing this form: _____

Relationship to patient: _____

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