LEVINE CHILDREN'S SLEEP MEDICINE QUESTIONNAIRE

Please bring this completed form to your appointment

Today's Date _____

Child's Name _____

Date of Birth _____ Age____

Mother's Name: _____

Father's Name: _____

Preferred Telephone #_____

Other Telephone #: _____

What is your ethnic background? (This question is optional)

❑ Caucasian ❑ Asian/Pacific Islander/Oriental ❑ African American
❑ Hispanic ❑ American Indian/Alaskan Native ❑ other (specify) _____

REFERRING PHYSICIAN:

Name _____ Telephone _____

Address _____

Please describe, in your own words, the reason you / your physician is seeking the evaluation for your child. Please include any information regarding previous sleep studies, if applicable.

_____

_____

_____

_____

_____

Initials _____/_____

BEDTIME ROUTINE	SCHOOL DAYS	NON-SCHOOL DAYS	SUMMER
Has consistent wake-sleep schedule?	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
Has daily Bedtime Routine?	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
Bedtime Routine: (please describe your child's daily bedtime routine)			

BEDTIME	SCHOOL DAYS	NON-SCHOOL DAYS	SUMMER
Usually GOES to bed at	_____ AM or PM	_____ AM or PM	_____ AM or PM
Usually FALLS asleep at	_____ AM or PM	_____ AM or PM	_____ AM or PM
Difficulty falling asleep?	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
Has difficulty finding comfortable position while trying to fall asleep.	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
Usually stalls bedtime...	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
Frequently gets in/out of bed with various requests such as "I am thirsty", "I need to use bathroom, "I am not tired", "I want to play" etc	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
Screen electronics device (iPad, smartphone, TV, Computer etc) usage prior to / around bedtime	❑ Yes ❑ No _____ Hours	❑ Yes ❑ No _____ Hours	❑ Yes ❑ No _____ Hours

NIGHT TIME SLEEP:	SCHOOL DAYS	NON-SCHOOL DAYS	SUMMER
Has difficulty staying asleep:	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
Usually wakes up during the night…	_____ times	_____ times	_____ times:
TOTAL NIGHT TIME SLEEP:	_____ Hours	_____ Hours	_____ Hours

Initials _____/_____

SLEEP ENVIRONMENT:			
Usually sleeps in	❑ His/her own bedroom ❑ Shares bedroom with sibling(s) ❑ Shares bed with sibling(s)		❑ Parent's bedroom on a separate bed/mattress ❑ Sleeps in same bed with parent ❑ Family / Living room ❑ Variable location
Does your child have the following is <u>IN the bedroom</u> where he / she usually sleeps?			
❑ Pet(s)	❑ Television	❑ Computer / laptop	❑ Handheld screen devices; smartphone, iPad, tablet
❑ Telephone	❑ Mobile phone	❑ Alarm clock	❑ Video games
❑ Other: ….			❑ Does not have any electronics devices in the room
When your child goes to bed at night he / she			
❑ Reads	❑ Works on homework	❑ Talks on phone	❑ Listens to music
❑ Watches TV	❑ Plays video games	❑ Uses computer / internet	

SLEEP ENVIRONMENT:	❑ Never	❑ Some nights	❑ Most nights	❑ Every night
Uses screen electronics devices such as TV, computer, video games etc prior to falling asleep.				
Uses <u>handheld</u> screen device such as smartphone, iPad, tablet, etc prior to falling asleep				
Watches TV in the bed prior to falling asleep.				
Falls asleep with TV on.				
Uses computer prior to falling asleep.				
Texts prior to falling asleep.				
Falls asleep while texting.				
Uses social medial prior to falling asleep.				
Uses video games prior to falling asleep.				
Frequent leg movements prior to falling asleep				
Rocks himself / herself to sleep				
Head banging prior to falling asleep				

Initials _____/_____

Does your child have any of the following symptoms routinely (AT LEAST once a week or more)?

SYMPTOMS	YES	NO	If Yes, Age of Onset	If Yes, Days per week
Difficulty falling asleep				
Difficulty staying asleep				
Snoring				
Snorting				
Mouth Breathing				
Choking/Gasping during Sleep				
Pauses in the breathing during sleep				
Struggling to Breathe / labored breathing during sleep				
Change in skin color				
Sleeps with his/her neck hyperextended (lifted up in the air)				
Excessive sweating during sleep.				
Cough				
Restless sleep				
Frequent night awakenings				
Awakening Frightened / Screaming				
Sleep terrors				
Nightmares				
Bed Wetting				
Teeth Grinding				
Sleep talking				
Sleep walking				
Behavioral concerns				
Irritable or Mood Swings				
Hyperactive				
Poor concentration				
Over Aggressiveness				
Frequent Leg movements during sleep				
Frequent Leg pains / discomfort,				
Creepy crawly feelings in the legs				
Is your child excessively tired during the day?				
Does your child fall asleep at school?				
Recent Decrease in School Performance				

What is your child's usual sleeping position?	❑ Stomach	❑ Side
	❑ Back	❑ Propped Up With _____Pillows
How would you describe the quality of your child's sleep?	❑ Excellent	❑ Fair
	❑ Good	❑ Poor

Initials _____/_____

WAKE UP TIME:	SCHOOL DAYS	NON-SCHOOL DAYS	SUMMER
Usually wakes up at	_____ AM or PM	_____ AM or PM	_____ AM or PM
Usually gets out of bed at	_____ AM or PM	_____ AM or PM	_____ AM or PM
Wakes up on his / her own?	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No

MORNING SYMPTOMS	SCHOOL DAYS	NON-SCHOOL DAYS	SUMMER
Wakes up on his/her own?			
Wakes up in good mood			
Appears well rested in the morning?			
Has difficulty waking up in the mornings			
Appears tired in the mornings?			
Appears miserable in the morning?			
Cranky, grumpy, irritable in the morning.			
Nonrestorative sleep, does not feel well rested…			
Morning headaches, sore throat, dry mouth etc.			
Misses school bus and/or is often late to school due to difficulty waking up in the morning.	❑ Yes ❑ No ❑ N/A		
Falls asleep on his / her way to school	❑ Yes ❑ No ❑ N/A		

DAYTIME SLEEP	SCHOOL DAYS	NON-SCHOOL DAYS	SUMMER
Daytime naps:	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
# naps per day or per week			
Length of the nap			
Time of the day			
Is your child excessively **sleepy** during the daytime?	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
Is your child excessively **tired** during the daytime?	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
TOTAL DAYTIME SLEEP:	_____ Hours	_____ Hours	_____ Hours

Initials _____/_____

ACADEMIC PERFORMANCE:

School:	Grade: (School year ……)	Returns home from school at ___
Day care:		❑ Yes ❑ No …. days/week
Enrolled in special education class?		❑ Yes ❑ No
Any concerns from school teachers?		❑ Yes ❑ No
Academic difficulties:		❑ Yes ❑ No
Ever repeated Grade?		❑ Yes ❑ No
Is your child's daytime performance at school, work or recreation less efficient than you would like it to be?		❑ Yes ❑ No
	LAST School Year? …….	**THIS School Year?**
ACADEMIC Grades	❑ Excellent ❑ Good ❑ Average ❑ Poor ❑ Failing	❑ Excellent ❑ Good ❑ Average ❑ Poor ❑ Failing
Number of MISSED School days		

REVIEW OF SYSTEMS: Does your child have any of the following symptoms?

General			**Respiratory**			**Neurological**		
Fever	**Y**	**N**	Chronic cough	**Y**	**N**	Hyperactivity	**Y**	**N**
Headaches	**Y**	**N**	Shortness of breath	**Y**	**N**	Poor attention span	**Y**	**N**
Loss of appetite	**Y**	**N**	Wheezing	**Y**	**N**	Tics	**Y**	**N**
Weight gain	**Y**	**N**	Difficulty with breathing	**Y**	**N**	Seizure	**Y**	**N**
Weight loss	**Y**	**N**	Nighttime cough	**Y**	**N**	Poor muscle tone	**Y**	**N**
Allergies / hay fever	**Y**	**N**						
Eyes			**Cardiovascular**			**Psychiatric**		
Dry eyes	**Y**	**N**	Chest pain	**Y**	**N**	Depression	**Y**	**N**
Red eyes	**Y**	**N**	Palpitations	**Y**	**N**	Anxiety	**Y**	**N**
Eye irritation	**Y**	**N**	Leg swelling	**Y**	**N**	Panic attacks	**Y**	**N**
Eye drainage	**Y**	**N**	Dizziness	**Y**	**N**	Change in personality	**Y**	**N**
Ears/Nose/Throat			**Gastrointestinal**			**Bones, Muscles & Joints**		
Stuffy / runny nose	**Y**	**N**	Difficulty swallowing	**Y**	**N**	Joint pain	**Y**	**N**
Difficulty breathing through nose	**Y**	**N**	Heartburn	**Y**	**N**	Joint swelling	**Y**	**N**
Dry nose	**Y**	**N**	Nausea, vomiting	**Y**	**N**	Muscle pain	**Y**	**N**
Nose bleed	**Y**	**N**	Abdominal pain	**Y**	**N**	Muscle weakness	**Y**	**N**
Dry mouth	**Y**	**N**						
Sore throat	**Y**	**N**	**Endocrine**			**Skin**		
Ear infections	**Y**	**N**	Diabetes	**Y**	**N**	Dry skin	**Y**	**N**
Sinus infections	**Y**	**N**	Thyroid Problem	**Y**	**N**	Skin irritation	**Y**	**N**
			Hormone Treatment	**Y**	**N**	Skin breakdown	**Y**	**N**

Initials _____/_____

SURGICAL HISTORY	YES	NO	DATE OF SURGERY
Enlarged Tonsils			
Enlarged Adenoids			
Facial Abnormality			
Sinus			
Bronchoscopy:			
Nasal polyp			
Nasal septum			
Others			

MEDICAL HISTORY:	YES	NO	If Yes; Age of onset
Enlarged Tonsils			
Enlarged Adenoids			
Recurrent ear infections			
Seasonal Allergies, Hay fever			
Nasal polyps			
Recurrent Croup			
Asthma			
Poor weight gain			
Rapid / excessive weight gain			
Reflux			
Swallowing difficulties			
Attention Deficit Hyperactivity Disorder			
Facial Abnormality			
Neurologic or Muscular Disorder			

Initials _____/_____

MEDICAL HISTORY:	YES	NO	If Yes; Age of onset
Seizure disorder			
Genetic Abnormality			
Down's syndrome			
Autism			
Developmental Disability			
Anxiety			
Depression			
Chronic pain syndrome			
Chronic fatigue syndrome			
Fibromyalgia			
Autoimmune disorders			
Thyroid hormone abnormalities			
Other(s)			

BIRTH HISTORY:

Born full term / pre-term - _____weeks early.	Complications during pregnancy or delivery? ❑ Yes ❑ No…. If yes, please describe

GROWTH AND DEVELOPMENT:

Appropriate for age? ❑ Yes ❑ No	**Physical therapy:** ❑ Yes ❑ No **Speech therapy:** ❑ Yes ❑ No **Occupational therapy:** ❑ Yes ❑ No **Participates in sports?** ❑ Yes ❑ No

Initials _____/_____

SOCIAL HISTORY:

Lives with… **Pets:** ❑ Yes ❑ No **Smoke exposure:** ❑ Yes ❑ No	**Caffeine beverages** such as chocolate milk, soda, energy drinks etc: (times and amount per day)

MEDICATION HISTORY:

ALLERGY HISTORY:

- Medication(s): ❑ Yes ❑ No _____
- Food(s): ❑ Yes ❑ No_____

Have you tried any medications in the past for sleep related symptoms? ❑ No ❑ Yes: If yes, please include:

Is your child presently taking any **prescription OR non-prescription** medication(s)? ❑ No ❑ Yes

NAME OF MEDICATION	Dosage	How Often

FAMILY HISTORY:

Initials _____/_____

PREVIOUS EVALUATION and TREATMENT:

Has your child had a previous sleep study? ❑ Yes ❑ No

If yes, where and when was the study done? Date: _____

Results (if available)

Treatment (s) tried

Does your child use CPAP / Bi-Level PAP / supplemental oxygen therapy? ❑ Yes ❑ No
If yes, what are the settings?

…….

Does your child snore while utilizing CPAP or Bi-Level PAP? ❑ Yes ❑ No

Have you been told that your child stops breathing during sleep while utilizing CPAP or Bi-Level PAP? ❑ Yes ❑ No

Side effects / complications.

Home Equipment: (CPAP, feeding pump…etc)	Home Monitors (pulse ox monitor…etc)
Home Care Company (DME): ❑ Yes ❑ No If yes; Name:	Home Nursing: ❑ Yes ❑ No If yes; ……. Hrs / day Name:

Initials _____/_____

SLEEPINESS: Pediatric Epworth Sleepiness Scale

How likely is your child to doze off or fall asleep in the following situations in contrast to just feeling tired? This refers to your usual way of life in recent times (such as…last 3 months).	
Scoring: Use the scale to the right to choose the most appropriate number for each situation	**0 = no chance of dozing** **1 = slight chance of dozing** **2 = moderate chance of dozing** **3 = high chance of dozing**

Situation	**Chance of Dozing**
1. Sitting and reading.	
2. Watching TV.	
3. Sitting inactive in a public place (e.g., a theatre or a classroom).	
4. As a passenger in a car for an hour without a break.	
5. Lying down to rest in the afternoon when circumstances permit.	
6. Sitting and talking to someone.	
7. Sitting quietly after lunch.	
8. While doing homework, taking a test, playing video games, texting on phone etc.	
Total:	_____

Initials _____/_____

SLEEPINESS: Pediatric Daytime Sleepiness Scale (PDSS)

Scoring: Use the scale to the right to choose the most appropriate number for each situation	**0 = Never** **1 = Seldom** **2 = Sometimes** **3 = Frequently** **4 = Always**

Situation	**SCORE**
1. How often do you fall asleep or get drowsy during class periods?	
2. How often do you get sleep or drowsy while doing your homework?	
3. Are you usually alert most of the day? (* Reverse score this item)	
4. How often are you ever tired and grumpy during the day?	
5. How often do you have trouble getting out of bed in the morning?	
6. How often do you fall back to sleep after being awakened in the morning?	
7. How often do you need someone to awaken you in the morning?	
8. How often do you think that you need more sleep?	
TOTAL:	_____

* Reverse score this item

Please bring this completed form to your appointment

…Thank you…

Atrium Health
Levine Children's

Initials _____/_____