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THE PERMANENTE MEDICAL GROUP

Division of Sleep Medicine

COMPLETED BY: ☐ **PARENT/GUARDIAN** ☐ **CHILD/ADOLESCENT**

Age: _____ Height: _____ Weight: _____

PEDIATRIC SLEEP QUESTIONNAIRE

Thank you completing this questionnaire. While there are many questions on this survey, it will help guide our visit today. Many questions will be clarified during the visit as well, so if you are unsure of answers, just do your best.

A. Nighttime and sleep behavior **WHILE SLEEPING, DOES YOUR CHILD …**	**Yes**	**No**	**Don't know**
… ever snore?			
… snore more than half the time?			
… always snore?			
… snore loudly?			
… have "heavy" or loud breathing?			
… have trouble breathing, or struggle to breathe?			
HAVE YOU EVER ...			
… seen your child stop breathing during the night? If so, please describe what happened:			
… been concerned about your child's breathing during sleep?			
… had to shake your sleeping child to get him or her to breathe, or wake up and breathe?			
… seen your child wake up with a snorting sound?			
DOES YOUR CHILD …			
… have restless sleep?			
… describe restlessness of the legs when in bed?			
… have "growing pains" (unexplained leg pains)?			
… have "growing pains" that are worst in bed?			
WHILE YOUR CHILD SLEEPS HAVE …			
… brief kicks in one or both legs?			
… repeated kicks or jerks of the legs at regular intervals (i.e. about every 20 to 40 seconds)?			

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AT NIGHT, DOES YOUR CHILD USUALLY …	Yes	No	Don't know
…become sweaty, or do the pajamas usually become wet with perspiration?			
… get out of bed (for any reason)?			
… get out of bed to urinate? If so, how many times each night, on average? _____			
Does your child usually sleep with the mouth open?			
Is your child's nose usually congested or "stuffed" at night?			
Does allergies affect your child's ability to breath to the nose?			
DOES YOUR CHILD …			
… tend to breathe through the mouth during the day?			
… have a dry mouth on waking up in the morning?			
… complain of an upset stomach at night?			
… get a burning feeling in the throat at night?			
… grind his or her teeth at night?			
… occasionally wet the bed?			
Has your child ever walked during sleep ("sleep walking")?			
Have you ever heard your child talk during sleep ("sleep talking")?			
Does your child have nightmares once a week or more on average?			
Has your child ever woken up screaming during the night?			
Has your child ever been moving or behaving, at night, in a way that made you think your child was neither completely awake nor asleep? If so, please describe what has happened:			
Does your child have difficulty falling asleep at night?			
How long does it take your child to fall asleep at night? (a guess is O.K.)			
At bedtime does your child usually have difficult "routines" or "rituals," argue a lot, or otherwise behave badly?			

Place patient label here

AT NIGHT, DOES YOUR CHILD USUALLY …	Yes	No	Don't know
… bang his or her head or rock his or her body when going to sleep?			
… wake up more than twice a night on average?			
… have trouble falling back asleep if he or she wakes up at night?			
… wake up early in the morning and have difficulty going back to sleep?			
Does the time at which your child goes to bed change a lot from day to day?			
Does the time at which your child gets up from bed change a lot from day to day?			
WHAT TIME DOES YOUR CHILD USUALLY …			
… go to bed during the week?			
… go to bed on the weekend or vacation?			
… get out of bed on weekday mornings?			
… get out of bed on weekends or vacation mornings?			
B. Daytime behavior and other possible problems: DOES YOUR CHILD …			
… wake up feeling unrefreshed in the morning?			
… have a problem with sleepiness during the day?			
… complain that he or she feels sleepy during the day?			
Has a teacher or other supervisor commented that your child appears sleepy during the day?			
Does your child usually take a nap during the day?			
Is it hard to wake your child up in the morning?			
Does your child wake up with headaches in the morning?			
Does your child get a headache at least once a month, on average?			
Did your child stop growing at a normal rate at any time since birth? If so, please describe what happened:			

Place patient label here	Yes	No	Don't know
Does your child still have tonsils? If not, when and why were they removed?			
HAS YOUR CHILD EVER …			
… had a condition causing difficulty with breathing? If so, please describe:			
… had surgery? If so, did any difficulties with breathing occur before, during, or after surgery?			
… become suddenly weak in the legs, or anywhere else, after laughing or being surprised by something?			
… felt unable to move for a short period, in bed, though awake and able to look around?			
Has your child felt an irresistible urge to take a nap at times, forcing him or her to stop what he or she is doing in order to sleep?			
Has your child ever sensed that he or she was dreaming (seeing images or hearing sounds) while still awake?			
Does your child drink caffeinated beverages on a typical day (cola, tea, coffee)? If so, how many cups or cans per day?			
Does your child use any recreational drugs? If so, which ones and how often?			
Does your child use cigarettes, smokeless tobacco, snuff, or other tobacco products? If so, which ones and how often?			

Place patient label here

HAS YOUR CHILD EVER …	Yes	No	Don't know
Is your child overweight? If so, at what age did this first develop?			
Has a doctor ever told you that your child has a high-arched palate (roof of the mouth)?			
Has your child ever taken Ritalin (methylphenidate) for behavioral problems?			
Has a health professional ever said that your child has attention-deficit disorder (ADD) or attention-deficit/hyperactivity disorder (ADHD)?			

Describe sleep problem in a few words:

Modified Pediatric Epworth Sleepiness Scale

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired? This refers to your usual way of life in recent times. Even if you have not done some of these things recently, think about how they would affected you. Use the following scale to choose 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	0	1	2	3
Sitting and reading	☐	☐	☐	☐
Watching television	☐	☐	☐	☐
Sitting inactive in a public place (i.e. a movie theater or classroom)	☐	☐	☐	☐
As a passenger in a car for an hour without a break	☐	☐	☐	☐
Lying down to rest in the afternoon	☐	☐	☐	☐
Sitting and talking to someone	☐	☐	☐	☐
Sitting quietly after lunch	☐	☐	☐	☐
Doing homework or taking a test	☐	☐	☐	☐

Total Score: _____