300 B Princeton Hightstown Rd.
E. Windsor NJ 08520 Suite 205
Phone: (609) 490- 1444
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CMD
Sleep Disorders Center

Pediatric Bedtime Questionnaire

1. At what time did your child go to bed last night? ___________________
2. How many hours of sleep did your child get last night? _____Hours _____Minutes
3. How did your child's sleep last night compare to his/her usual sleep?

	BETTER	THE SAME	WORSE
Time to Fall Asleep			
Awakenings			
Number of Hours Slept			

4. Did your child nap today?
   NO YES If yes, at what time? ___________ How long was the nap? ______________

5. Has today been an unusual day in any way? NO YES (Explain)
   ____
   ____

6. Did your child take any medications today? NO YES (Please Specify)

MEDICATIONS	TIME	DOSE

7. Does your child have any physical complaints tonight (cold, stuffy nose, pains, others)?
   ____
   ____

Pediatric Morning Questionnaire

1. How would you rate your child's sleep last night compared to his/her usual sleep?

	BETTER	THE SAME	WORSE
Time to Fall Asleep			
Awakenings			
Number of Hours Slept			

Other comments about your child's sleep here.
____
____

Patient Name: ____________________________ Date of Birth: ___/___/_____ Date of Study: ___/___/_____

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2. Were any awakenings due to external stimuli (explain, i.e. fire alarms, door closing, people talking, or phone ringing)?
   ____

3. Did your child take any medication while at the sleep center? If yes, please specify.

MEDICATIONS	TIME	DOSE

4. If your child received nasal CPAP or BiPAP therapy, do you feel it improved the overall quality of his/her sleep?
   ____
   ____

5. Do you have any comment or suggestions? ____
   ____
   ____

Patient Name: ___________________________ Date of Birth: ___/___/_____ Date of Study: ___/___/_____