300 B Princeton Hightstown Rd.
E. Windsor NJ 08520 Suite 205
Phone: (609) 490- 1444
Fax: (609) 490 -1133
cmdsleep@live.com

Pediatric Sleep Questionnaire

Name:	DOB:	Age:	Date:
What does your child like to be called?		Male	Female
Home Ph.#	Work Ph.#	Cell Ph.#	
Referring MD:	Primary MD:		
Height	Weight		

PRESENT HISTORY/SLEEP HISTORY:

What are your main concerns regarding your child's health today?

Does your child snore?	YES	NO	How Often?
Only with a cold/infection			
Does your child sleep restlessly/flip and flop at night?		YES	NO
Are you concerned about your child's breathing when asleep?		YES	NO
Is your child a mouth-breather?	Usually	Occasionally	Rarely
If toilet trained, does your child wet the bed?	NO	Occasionally	Frequently
Does your child seem tired during the day?		YES	NO
Does your child seem hyperactive to you?		YES	NO
Do you have concerns about ADD or ADHD in your child?		YES	NO
Does your child have frequent nasal drainage/sinus infection?		YES	NO
Does your child have frequent sore throats?		YES	NO
Does your child have frequent ear infections?		YES	NO
Has your child had Ear tube surgery?		YES	NO
Do you have concerns about your child's growth or weight?		YES	NO
If yes above, describe.			
Has your child had surgery on the tonsils and/or adenoids?	Date of surgery:		NO
Circle what was removed		Tonsils	Adenoids

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SLEEP SCHEDULE:

	Weekday	Weekend
What time is Bed Time?		
What time do they wake-up?		
What is your child's bedtime routine?		
Does your child have difficulty going to sleep?	YES	NO
Does your child wake up frequently at night?	YES	NO
Number of awakenings/night		
Does your child kick at night?	YES	NO
Complain of leg pain?	YES	NO
Is your child difficult to awaken in the morning?	YES	NO

PAST MEDICAL HISTORY / SOCIAL HISTORY:

Was pregnancy and delivery of your child normal?	YES	NO
Please list any other medical problems/history related to your child:		
Please estimate the number of caffeinated drinks your child has daily		
Time of day consumed		
Does your child have a history of psychological/psychiatric problems?	YES	NO
Please list any details about this that you feel will be helpful in the care of your child:		
Present grade in school:		
How do you feel your child is doing if in school?		
In your child's bedroom, is there a TV?	YES	NO
Is there a computer?	YES	NO
Does your child share a bedroom?	YES	NO
If yes, age of roommate		

FAMILY HISTORY:

Is there a family history of any sleep problems? List relationship to child and type of problem:

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CMD
Sleep Disorders Center

MEDICATIONS:

List all medications (OTC, minerals, herbals, supplements, weight loss aids).

Medication Name	**Dose**	Freq	Usual Time of Last Dose	Reason	Ordering MD