PEDIATRIC (age < 16) SLEEP MEDICINE HISTORY ***St Elizabeth Sleep Disorders Centers***

Name ___________________________________ Date of Birth ___________ Date___________

Reason for my visit: ____

PLEASE COMPLETE ALL ITEMS ☑ ***CHECK IF TRUE***

- ☐ I have been **abnormally sleepy / tired** for _______ months
- ☐ I usually **do not feel rested** after sleep
- ☐ I tend to be **sleepy when** reading, watching TV, talking, riding in a car or eating
- ☐ **Sleepiness interferes** with my schoolwork, memory or social life
- ☐ I have **attention deficit disorder** (ADD or ADHD)

- ☐ I have had **prior treatment** for sleep apnea at ________________________________
- ☐ Someone has **witnessed** (seen or heard) me stop breathing when I sleep
- ☐ I wake up **gasping, choking** or smothering for air
- ☐ I have loud, disruptive **snoring**
- ☐ Need to **go to the bathroom** _____ times per night
- ☐ I **wet the bed** _____ times per month
- ☐ My **close relative** (_________________) **has sleep apnea**

- ☐ I have moderate or severe **lung disease**
- ☐ I have **pulmonary hypertension** (high blood pressure in the lungs)
- ☐ I have **congestive heart failure** and shortness of breath with regular activity or at rest
- ☐ I have an **uncontrolled heart rhythm disorder** (rapid, slow or irregular pulse)
- ☐ I have a **neurologic disease that affects my breathing**

- ☐ I tend to **kick or move my arms** a lot when I sleep (Periodic Limb Movements)
- ☐ I have had **hallucinations** while falling asleep or waking up
- ☐ I have been **paralyzed** (can't move) while falling asleep or waking up
- ☐ I may have had a **seizure while asleep**
- ☐ I get an irresistible **urge to move my legs or arms** due to crawling or tingling (RLS)
- ☐ I awaken from sleep **screaming and feeling terrified** (night terrors)
- ☐ I have a lot of **frightening dreams** (nightmares)

Sleep Habits	Bedtime	Up for the Day	Total Sleep / Day
Week days / School days	_______am/pm	_______am/pm	________hours
Week ends / Days off	_______am/pm	_______am/pm	________hours

☐ I spend **time in my bedroom** awake

☐ I usually **sleep in** on days off

☐ I **watch TV or read in bed** before sleep

☐ If I can't sleep, I **stay in my bedroom**

It takes me _______**minutes to fall asleep**

I wake up _______ times at night

☐ I have had **trouble getting to sleep or staying asleep** for _______ months

☐ My **mind races** when I try to sleep

☐ It is **difficult to go back to sleep**

☐ I am a light, **restless** sleeper

☐ I use **sleeping pills** or **alcohol** to sleep

☐ I have **trouble sleeping** due to ____

Review of Systems

CONSTITUTIONAL: ☐ Gained weight (____ lb) in the past year

EAR NOSE THROAT: ☐ Frequent sinus congestion ☐ Frequent nosebleeds
☐ Other ear/nose/throat problem ______________________________

CARDIOVASCULAR: ☐ High blood pressure
☐ Other heart problem ______________________________

RESPIRATORY: ☐ Asthma during sleep ☐ Home oxygen (____ L/min)
☐ Other lung disease ______________________________

GASTROINTESTINAL: ☐ GERD (heartburn) at night
☐ Other stomach or intestine problem ______________________________

GENITOURINARY: ☐ Wet the bed
☐ Other kidney / genital problem ______________________________

MUSCULOSKELETAL: ☐ Bone or joint pain disturbs sleep
☐ Other bone / joint problem ______________________________

NEUROLOGICAL: ☐ Muscle weakness
☐ Other nerve or muscle problem ______________________________

PSYCHIATRIC: ☐ Chronic anxiety ☐ Depression
☐ Other emotional problem ______________________________

ENDOCRINE: ☐ Thyroid underactive ☐ Diabetes
☐ Other hormone problem ______________________________