

PEDIATRIC QUESTIONNAIRE

Patient name: _____ Date: _____

Age: _____ Referring Physician: _____

Briefly describe reason for visit: _____

List current medications:	List medication allergies:

Family history:		Social history:		
	Family member		How much	Time of day consumed
Snoring		Caffeine use: <input type="checkbox"/> YES or <input type="checkbox"/> NO		
Sleep apnea		Tobacco use: <input type="checkbox"/> YES or <input type="checkbox"/> NO		
Narcolepsy		Drug use: <input type="checkbox"/> YES or <input type="checkbox"/> NO		
Restless legs		Who does child live with? _____		
Heart attack or sudden death <i>(before the age of 50)</i>		Current grade _____	Classes: <input type="checkbox"/> regular <input type="checkbox"/> advanced <input type="checkbox"/> special education	
		Grades average (circle all that apply): A's B's C's D's F's		
		Ever stayed back in school? <input type="checkbox"/> YES or <input type="checkbox"/> NO		
		If yes, what grade _____		

Medical history		
<input type="checkbox"/> ADHD	<input type="checkbox"/> Cerebral Palsy	<input type="checkbox"/> Sickle cell anemia/trait
<input type="checkbox"/> Anxiety	<input type="checkbox"/> Chromosome problem	<input type="checkbox"/> Thyroid disorder
<input type="checkbox"/> Asperger Syndrome	<input type="checkbox"/> Craniofacial abnormality	<input type="checkbox"/> Tonsillectomy (what year? _____)
<input type="checkbox"/> Autism	<input type="checkbox"/> Depression	<input type="checkbox"/> Adenoidectomy (what year? _____)
<input type="checkbox"/> Asthma	<input type="checkbox"/> Developmental delay	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Behavioral concerns	<input type="checkbox"/> Obesity	<input type="checkbox"/> Other: _____

Birth History (if less than 5 y/o)
<input type="checkbox"/> Term or <input type="checkbox"/> Pre-term (If pre-term, how many weeks early? _____)

Sleep schedule		
Bedtime?	_____ minutes	If your child naps, how often and how long?
Falls asleep in?	_____ minutes	Does he/she feel refreshed after napping?
Wakes up?	_____ times/night	Weekend / Vacation Schedule
Cause of awakenings?		Bedtime: _____
Returns to sleep in?	_____ minutes	Wake time: _____
Wake up time?		Sleep routine (if present)

Complete the next questions for ages 12 and up only.		Briefly describe routine (ex. bath / brush teeth / read / lights out)	
What time does your child feel most awake?	_____	_____	
What time does your child feel the sleepiest?	_____		
How long does routine last: _____			

Please answer	YES	NO	Sleep Environment
Sleepwalk?			<input type="checkbox"/> Quiet or <input type="checkbox"/> Loud
Night terrors?			<input type="checkbox"/> Dark or <input type="checkbox"/> Bright or <input type="checkbox"/> nightlight
Nightmares?			<input type="checkbox"/> Own bed or <input type="checkbox"/> Parents bed or <input type="checkbox"/> Siblings bed
			<input type="checkbox"/> Own room or <input type="checkbox"/> Parents room or <input type="checkbox"/> Siblings room

Section I.	Yes	No
Does your child snore?		
If yes, how long has your child snored? _____ months or _____ years		
Do you see or hear your child stop breathing during the night?		
Does your child sleep restlessly or get sweaty during the night?		
Does your child get up to urinate during the night?		
Does your child have a hard time waking up in the morning?		
Does your child have morning headaches?		
Does your child have nasal congestion or dry mouth in the morning?		
Does your child feel sleepy during the day?		
Does your child have seasonal allergies?		
Does your child make careless mistakes at school?		
Is your child easily distracted or always “on the go”?		
Is your child overweight?		

Section II.	Yes	No
Does your child complain of creepy-crawly feelings in the legs?		
Is there an urge to move the legs?		
What makes symptoms worse? _____		
Do these symptoms interfere with falling asleep?		
Has your child suffered a severe back or head injury?		
Does your child have diabetes?		

Section III.	Yes	No
Does your child ever feel paralyzed?		
Does your child see or hear things that aren't really there?		

ROS (please mark appropriate for any system you have problems with)					
Symptoms	Yes	No	Symptoms	Yes	No
History of severe head trauma			Difficulty swallowing		
Change in hearing			Reflux/heartburn		
Change in vision			Urgency to urinate		
Nasal congestion			Frequent urination		
Recurrent sinus infections			Joint Pain		
Fast heart beat			Muscle Pain		
Cough			Swelling of extremities		
Asthma			Tingling of extremities		
Frequent colds			Chronic Pain (where? _____)		
Nausea			Excessive thirst		
Vomiting			Intolerance to heat		
Constipation			Intolerance to cold		
Diarrhea			Easy bruising or bleeding		
Pain with swallowing			Eczema		