ARKANSAS CENTER for SLEEP MEDICINE
Paul Wylie, MD
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PEDIATRIC SLEEP DISORDERS INITIAL EVALUATION QUESTIONNAIRE

******You must bring this form, FULLY COMPLETED, with you to your appointment.**
DO NOT plan to complete this form after you arrival at our office.
This form is a very important part of your child's initial evaluation.
Failure to **FULLY COMPLETE** this form **PRIOR TO YOUR CHILD'S APPOINTMENT**
Will result in the need to reschedule your evaluation.

Patient's Name: ____
Last First Middle

Today's Date: __________ DOB: ___________ Age: ______ Sex: _____

Father's Name ____
Last First

Mother's Name ____
Last First

Who referred you or how did you locate our practice? ________________________

Who is your primary physician? ________________________________

What is the major concern(s) of the patient's sleep? ________________________

____

____

Allergies: ____

List of Medications: Name of Medicine Dose/ How Often Taken For

____

____

____

____

Surgeries/Hospitalizations: Circle Yes or No

1. Has the patient had his/her tonsils removed? Yes No Age of surgery: ______
2. Has the patient had his/her adenoids removed? Yes No Age of surgery: ______
3. Has the patient ever had ear tubes? Yes No Age of surgery: ______

Please list any other hospitalizations or surgeries:

____

____

____

Current Sleep Symptoms: Circle Yes or No

1. Difficulty breathing when asleep	Yes	No
2. Stops breathing when asleep	Yes	No
3. Snores	Yes	No
4. Restless sleep	Yes	No
5. Sweating when asleep	Yes	No
6. Nightmares	Yes	No
7. Sleepwalking	Yes	No
8. Sleeptalking	Yes	No
9. Screaming in his/her sleep	Yes	No
10. Trouble staying in his/her bed	Yes	No
11. Resists going to bedtime	Yes	No
12. Grinds his/her teeth	Yes	No
13. Wets bed	Yes	No
14. Daytime sleepiness	Yes	No

15. Falls asleep in school Yes No

16. Naps after school Yes No

17. Trouble getting up in the mornings Yes No

18. Feels weak or loss of control of muscles With strong emotions Yes No

19. Reports unable to move when falling asleep Or upon awakening Yes No

20. Kicks legs in sleep Yes No

21. Uncomfortable feeling in his/her legs; Creepy-crawly feeling Yes No

SLEEP HISTORY

1. Usual **bedtime** on **weekday** nights? ______________________________

2. Usual **waketime** on **weekday** mornings? ______________________________

3. Usual **bedtime** on **weekends/vacations.** ______________________________

4. Usual **waketime** on **weekends/vacations.** ______________________________

5. Number of days patient takes a **nap** each week? ______________________________

6. If patient naps, how long do the naps last? ______________________________

7. Number of **naps** does patient take on the weekend and length? ______________

8. Does patient have a regular bedtime routine? Yes No

9. Does patient have his/her own bedroom? Yes No

10. Does the patient sleep in his/her own bed all night? Yes No

11. What does the patient have access to in his/her room? Circle all that apply.

TV IPOD Computer Cell Phone Texting

What time is lights out at bedtime? ______________________________

12. How long does it take once lights are out to go to sleep? ____________
13. If awakenings occur during the night, what time do they occur? ______
14. How long does it take to get back to sleep? ______________________
15. What causes awakenings? Circle all that apply.

Going to bathroom Cell phone Texting TV Noise

Light Nightmares

SCHOOL PERFORMANCE

1. What grade is patient in? ____________________
2. How are the patients grades? ____ Good ____ Fair ____ Poor
3. Is the teacher expressing any concern on behavior? ____ Yes ___ No

   If so, what are the teachers concerns? ______________________________

   ____

   ____

4. Is patient falling asleep in class? _____ Yes ____ No
5. Is patient frequently tardy or absent from class? ____ Yes ___ No
6. Is the patient enrolled in any special education classes? __ Yes __ No
7. What activites are the patient involved in at school? _______________

   ____

Does the patient experience any of the following: Circle appropriate ones.

Moodiness Irritability Anger Depression Anxiety

ADHD Migraines Traumatic Event

PAST MEDICAL HISTORY

1. Sinus problems	Yes	No
2. Trouble breathing through his/her nose	Yes	No
3. Frequent nasal congestion	Yes	No
4. Frequent ear infections	Yes	No
5. Difficulty swallowing	Yes	No
6. Speech problems	Yes	No
7. Seizures/Epilepsy	Yes	No
8. Morning headaches	Yes	No
9. Cerebral palsy	Yes	No
10. Poor or delayed growth	Yes	No
11. Depression	Yes	No
12. ADHD	Yes	No
13. Learning disability	Yes	No
14. Behavior disorder	Yes	No
15. Drug use/abuse	Yes	No
16. Anxiety/Panic attacks	Yes	No
17. Gastrointestinal Reflux	Yes	No

Family Medical History

Please list on the lines below the affected family member(s) for any of the listed disorders That are present in your genetic biological family.

Insomnia: ______________________________

Snoring: ______________________________

Sleep apnea: ______________________________

Narcolepsy: ______________________________

Restless Leg Syndrome: ______________________________

Periodic Limb Movement Disorder: ______________________________

Diabetes: ______________________________

Kidney Disease: ______________________________

Cancer- list the type: ______________________________

Thyroid Disease: ______________________________

Sudden death during sleep: ______________________________