FirstHealth OF THE CAROLINAS

7034.07.15217.06 ped Sunset Date: 7/2024

Sleep History-Pediatric

3ANCSA001

Place Patient Label
Inside This Box

FirstHealth Moore Regional Hospital: ☐ *Moore* ☐ *Richmond*
FirstHealth Montgomery Memorial Hospital: ☐

PATIENT NAME:_____

AGE: _____ SEX: _____ HEIGHT: _____ WEIGHT: _____

REFERRING PHYSICIAN: _____ PHONE: _____

What is your main concern about your child's sleep?

_____

_____

When did this problem begin? _____ Is It Getting Worse? ☐No ☐Yes

Has your child ever had a sleep study? ☐No ☐Yes If Yes, When? _____ Results: _____

Weekly Sleep Schedule

How many naps does your child take during the day?		Length of naps?	
Child's usual bedtime on weekdays?		Child's usual bedtime on weekends?	
Child's usual wake time on weekdays?		Child's usual wake time on weekends?	

Write in the amount of time your child sleeps during a 24 hour period on weekdays (add daytime and nighttime sleep):

_____hours _____minutes

Sleep Environment

1. Where does your child usually sleep? _____
2. Does your child sleep alone? ☐No ☐Yes
3. Does your child watch TV/play video games while in bed? ☐No ☐Yes
4. Does your child have their own room? ☐No ☐Yes
5. Is your child able to fall asleep on their own? ☐No ☐Yes
   a. Does your child wake during the night? ☐No ☐Yes
      If Yes, How Many Times? _____

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Current Sleep Problems

1.	Difficulty Breathing When Asleep	☐No	☐Yes
2.	Stops Breathing During Sleep	☐No	☐Yes
3.	Snores Or Noisy Breathing While Asleep	☐No	☐Yes
4.	Restless Sleep/Tossing And Turning	☐No	☐Yes
5.	Sweating While Sleeping	☐No	☐Yes
6.	Daytime Sleepiness/Naps After School	☐No	☐Yes
7.	Falls Asleep In School	☐No	☐Yes
8.	Nightmares/Night Terrors	☐No	☐Yes
9.	Sleep talks	☐No	☐Yes
10.	Kick or moves arms/legs during sleep	☐No	☐Yes
11.	Wets the bed	☐No	☐Yes
12.	Creepy-crawly/uncomfortable feeling in legs	☐No	☐Yes
13.	Resists going to bed	☐No	☐Yes
14.	Wakes up at night	☐No	☐Yes
15.	Gets out of bed at night	☐No	☐Yes
16.	Grinds teeth while asleep	☐No	☐Yes
17.	Trouble getting up in the morning	☐No	☐Yes
18.	Sees frightening images before falling asleep	☐No	☐Yes
19.	Feels weak or loses control of muscles suddenly with strong emotions (laughter, anger, crying, etc.) while awake	☐No	☐Yes
20.	Screaming in sleep	☐No	☐Yes

Past Medical History

1.	Frequent nasal congestion/ Sinus problems	☐No	☐Yes	
2.	Trouble breathing through nose	☐No	☐Yes	
3.	Enlarged tonsils/Enlarged adenoids	☐No	☐Yes	
4.	Chronic cough/Bronchitis	☐No	☐Yes	
5.	Allergies	☐No	☐Yes	
6.	Asthma	☐No	☐Yes	
7.	Frequent colds or flu	☐No	☐Yes	
8.	Frequent strep throat	☐No	☐Yes	
9.	Had tonsils removed	☐No	☐Yes	If Yes, Age:_____
10.	Frequent ear infections	☐No	☐Yes	
11.	Ear tubes placed	☐No	☐Yes	If Yes, Age:_____
12.	Difficulty swallowing	☐No	☐Yes	

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13. Acid reflux / GERD	☐No	☐Yes
14. Poor or delayed growth	☐No	☐Yes
15. Excessive weight	☐No	☐Yes
16. Neurologic or muscular disorder	☐No	☐Yes
17. Cerebral Palsy	☐No	☐Yes
18. Seizure/Epilepsy	☐No	☐Yes
19. Morning headaches	☐No	☐Yes
20. Chromosomal disorder (e.g. Down's syndrome)	☐No	☐Yes
21. Skeleton problems (e.g. Dwarfism)	☐No	☐Yes
22. Genetic disorder	☐No	☐Yes
23. Craniofacial disorder (e.g. Pierre-Robin)	☐No	☐Yes
24. Thyroid problems	☐No	☐Yes
25. Meningitis	☐No	☐Yes
26. Autism	☐No	☐Yes
27. Developmental Delay	☐No	☐Yes
28. Hyperactivity/ ADHD	☐No	☐Yes
29. Anxiety / Panic Attacks	☐No	☐Yes
30. Obsessive Compulsive Disorder	☐No	☐Yes
31. Depression	☐No	☐Yes
32. Suicide	☐No	☐Yes
33. Learning disabilities	☐No	☐Yes
34. Drug use/ abuse	☐No	☐Yes
35. Behavioral disorder	☐No	☐Yes
36. Psychiatric admission	☐No	☐Yes

Birth History:

Any problems with pregnancy or delivery? ☐No ☐Yes If Yes, please specify: _____

Was your child born on time? ☐No ☐Yes If No, How Many Weeks?_____

What was your child's birth weight? _____Lbs _____Oz

Please list any hospitalizations or other medical diagnosis your child has had below:

_____

_____

_____

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Does Your Child Take Any Medications? ☐No ☐Yes

If Yes please list names, dosage, and reason for taking them (e.g. blood pressure):

NAME	DOSAGE	REASON TAKEN

Does anyone in your family (blood relatives only) have a history of any of the following sleep problems?

1. Insomnia (Inability To Fall Asleep) ☐No ☐Yes Relation:_____
2. Sleep Apnea ☐No ☐Yes Relation: _____
3. Restless Leg Syndrome ☐No ☐Yes Relation:_____
4. Periodic Limb Movements in Sleep (PLMS) ☐No ☐Yes Relation:_____
5. Sleepwalking/sleep terrors ☐No ☐Yes Relation:_____
6. Sleep talking ☐No ☐Yes Relation:_____
7. Narcolepsy (inability to stay awake) ☐No ☐Yes Relation:_____
8. Snoring ☐No ☐Yes Relation:_____

School Performance (If Of School Age)

1. Have you noticed a recent change in your child's school performance? ☐No ☐Yes
2. What grade is your child in? _____
3. Has your child every repeated a grade? ☐No ☐Yes
   If yes, what grade(s) _____
4. Is your child enrolled in any special education classes? ☐No ☐Yes
   How many school days has your child missed so far this year?_____ _____
5. How many school days did your child miss last year? _____
6. How many school days has your child been late? _____
7. How many school days was your child late last year? _____
8. Child's grades this year? ☐Excellent ☐Good ☐Average ☐Poor ☐Failing
9. Child's grades last year? ☐Excellent ☐Good ☐Average ☐Poor ☐ Failing

What does your child like to do in their spare time (hobbies, crafts, organizations, clubs, and sports)? Please list:

_____

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Does Anyone In The House Smoke? ☐No ☐Yes

How much of the following beverages containing caffeine does your child drink in an average 24 hour period

Coffee_____ Tea_____ Coca-Cola_____

Please add any comments or problems not listed in this questionnaire:

_____

_____

_____

Parent/Guardian Signature: _____Date:_____Time:_____

Technologist Signature: _____ Date:_____Time:_____