

**LEHIGH VALLEY HOSPITAL**  
1627 West Chew Street  
Allentown, PA 18102  
**SLEEP DISORDERS CENTER**  
(610) 969-4277

**PEDIATRIC SLEEP QUESTIONNAIRE**

This questionnaire is needed to obtain necessary information regarding your child=s medical history and sleep related problems. It will be used to help interpret your child=s sleep study. Please answer all of the following questions by filling in the blanks or circling the appropriate answer. You may omit questions that you feel do not apply to your child or that you do not wish to answer. Bring this form with you to your child=s sleep study. Your cooperation is appreciated and your confidentiality is assured.

Today=s Date: \_\_\_\_\_

Child=s Name: \_\_\_\_\_ Sex: M \_\_\_\_\_ F \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Mother=s Name: \_\_\_\_\_ Father=s

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone (Home): \_\_\_\_\_ Telephone (Work): \_\_\_\_\_

What is your ethnic background? (This question is optional)

_____ Caucasian	_____ Asian/Pacific Islander/Oriental
_____ African American	_____ American Indian/Alaskan Native
_____ Hispanic	_____ Other (specify) _____

**Referring Physician:**

Name: \_\_\_\_\_ Telephone: \_\_\_\_\_

Address: \_\_\_\_\_

If there are other physicians you would like to receive a copy of your child=s report, please provide the full names and addresses below:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**CLINICAL HISTORY:**

Has your child had a previous sleep study? YES / NO

If yes, where and when was study done? \_\_\_\_\_

\_\_\_\_\_

Please describe in your own words the reason you are seeking this evaluation for your child. Please include any information regarding previous sleep studies if applicable.

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Does your child have any of the following problems routinely (once a week or more) during sleep?

Problem	No	Yes	If Yes, Age of Onset	If Yes, Days per Week
Snoring				
Choking/Gasping in Sleep				
Stopping Breathing				
Struggling to Breathe				
Mouth Breathing				
Restless Sleep				
Frequent Leg Movements				
Teeth Grinding				
Body Rocking/Head Banging				
Nightmares				
Awakening Frightened/Screaming				
Bed Wetting				
Night Sweating				

Does your child have any of the following:

Problem	No	Yes	Age of Onset
Excessive Daytime Sleepiness/Tiredness			
Enlarged Tonsils			
Enlarged Adenoids			
Nasal Allergies/Hayfever			
Medication Allergies (please describe)			
Other Allergies (please describe)			
Asthma			
Failure to Gain Weight			

Neurologic or Muscular Disorder			
Facial Abnormality			
Attention Deficit Hyperactivity Disorder			
Over Aggressiveness			
Irritable or Mood Swings			
Recent Decrease in School Performance			
Frequent Leg Pain or Discomfort			
Frequent Rubbing of Legs			
Other:			

Has your child had surgery for any of the following?

Problem	No	Yes	Date of Surgery
Enlarged Tonsils			
Enlarged Adenoids			
Facial Abnormality			
Other:			

**SLEEP HISTORY:**

What time does your child usually go to bed on weeknights? \_\_\_\_\_ Weekends? \_\_\_\_\_

What time does your child usually wake up on weekdays? \_\_\_\_\_ Weekends? \_\_\_\_\_

How long does it usually take for your child to fall asleep after lights out? \_\_\_\_\_  
(minutes)

On an average night, how many times does your child wake up?

- |                    |                       |
|--------------------|-----------------------|
| _____ Never        | _____ 5 or 6 Times    |
| _____ 1 or 2 Times | _____ 7 or 8 Times    |
| _____ 3 or 4 Times | _____ 9 or More Times |

If your child does wake up during the night, how long does it usually take for him/her to go back to sleep?

- |                          |                          |
|--------------------------|--------------------------|
| _____ 10 minutes or less | _____ 30-60 minutes      |
| _____ 10-20 minutes      | _____ More than One Hour |
| _____ 20-30 minutes      |                          |

How many days per week does your child wake up early and then can not go back to sleep?

- |                            |                               |
|----------------------------|-------------------------------|
| _____ Never                | _____ 3 or 4 Days Per Week    |
| _____ 1 or 2 Days Per Week | _____ 5 or More Days Per Week |

How would you describe the quality of your child=s sleep?

\_\_\_\_\_ Excellent  
\_\_\_\_\_ Good  
\_\_\_\_\_ Fair  
\_\_\_\_\_ Poor

What is your child=s usual sleeping position?

\_\_\_\_\_ Stomach  
\_\_\_\_\_ Back  
\_\_\_\_\_ Side  
\_\_\_\_\_ Propped Up With Pillows

How many nights per week does your child sleep in the same room as you or another primary caretaker?

\_\_\_\_\_ Never  
\_\_\_\_\_ 1 or 2 Days Per Week  
\_\_\_\_\_ 3 or 4 Days Per Week  
\_\_\_\_\_ 5 or More Days Per Week

How often does your child take naps?

\_\_\_\_\_ Rarely or Never  
\_\_\_\_\_ 1 or 2 Times per Week  
\_\_\_\_\_ 3 or 4 Times per Week  
\_\_\_\_\_ 5 or More Times Per Week  
\_\_\_\_\_ More than Once Per Day

If your child does take naps, how long do the naps last?

\_\_\_\_\_ 10-30 minutes  
\_\_\_\_\_ 30-60 minutes  
\_\_\_\_\_ 1-2 Hours  
\_\_\_\_\_ More than Two Hours

Is there anything else that is unusual about your child=s sleeping patterns or breathing during sleep?

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Does anyone in the family (parents, grandparents, siblings, etc.) have sleep apnea or other sleep disorder? YES / NO

Please explain: \_\_\_\_\_  
\_\_\_\_\_

**MEDICATION HISTORY:**

Is your child presently taking any prescription or non-prescription medications (other than vitamins)? YES / NO

If Yes, please list:
