Children's Mercy HOSPITALS & CLINICS

Sleep Clinic
Caregiver Questionnaire

7030-005 MR 03/13

Patient Name: _____ Date of Birth: ____/____/____

Referring Physician: _____ Office Phone Number: (____)_____-_____

Address: _____
Street City State Zip

What are your main sleep concerns? _____

_____

_____

Has your child had a previous sleep evaluation? ☐ No ☐ Yes (see below)

Name of Hospital or Sleep Center: _____

Address: _____
Street City State Zip

Has your child had a sleep study? ☐ No ☐ Yes, approximate date: _____

Current Medications (including prescribed, over-the-counter, herbal preparations, and dietary supplements): ☐ None

_____

_____

_____

Past Medical History

1. Was the child born prematurely? ☐ No ☐ Yes, how many weeks early? _____
   If yes, were there complications? ☐ No ☐ Yes, explain: _____
2. Has the child's weight changed in the last 6 months? ☐ No ☐ Yes, gained _____ pounds ☐ Yes, lost _____ pounds
3. Has the child had his/her tonsils removed? ☐ No ☐ Yes, at what age? _____
4. Has the child ever had surgery? ☐ No ☐ Yes, what kind and at what age? _____
5. Does the child have any medical problems? ☐ No ☐ Yes, describe: _____

   _____

   _____
6. Has the child ever had to stay in the hospital? ☐ No ☐ Yes, why? _____

   _____

Family History

Have the child's *blood* relatives (parents, grandparents, aunts, uncles, brothers, sisters), living or deceased, had a sleep disorder? Check all that apply.

☐ No ☐ Obstructive sleep apnea ☐ Narcolepsy ☐ Restless leg syndrome (RLS) ☐ Periodic limb movement (PLM)

☐ Other (describe): _____

_____ _____
Signature of Person Completing This Form Printed Name of Person Completing This Form

_____ ____/____/____ _____ hours
Relationship to Child Date Time

STAFF USE ONLY

Social History: _____

_____

Review of Systems

☐ General: _____ ☐ Skin: _____
☐ Eyes: _____ ☐ Musculoskeletal: _____
☐ ENT: _____ ☐ Neurological: _____
☐ Respiratory: _____ ☐ Behavioral/Mental Status: _____
☐ Cardiovascular: _____ ☐ Hematologic/Lymphatic: _____
☐ Gastrointestinal: _____ ☐ Allergic/Immunologic: _____
☐ Genitourinary: _____ ☐ Endocrine/Growth: _____

☐ See review of systems dated ____/____/____ ☐ Reviewed with patient/family. ☐ All Other Systems Negative

Reviewed By: _____ _____ ____/____/____ _____ hours
Signature Title Date Time

Patient Name:_____ **Date:**_____

Instructions:

Please answer the questions on the following pages regarding the behavior of your child during sleep and wakefulness. The questions apply to how your child acts in general, not necessarily during the past few days since these may not have been typical if your child has not been well. If you are not sure how to answer any question, please feel free to ask your husband or wife, child, or physician for help. You should circle the correct response or *print* your answers neatly in the space provided. A "Y" means "yes," "N" means "no," and "DK" means "don't know." When you see the word "usually" it means "more than half the time" or "on more than half the nights."

A. Nighttime and sleep behavior:		Office use only
WHILE SLEEPING, DOES YOUR CHILD ...		
... ever snore?	Y N DK	A1
... snore more than half the time?	Y N DK	A2
... always snore?	Y N DK	A3
... snore loudly?	Y N DK	A4
... have "heavy" or loud breathing?	Y N DK	A5
... have trouble breathing, or struggle to breathe?	Y N DK	A6
HAVE YOU EVER ...		
... seen your child stop breathing during the night? If so, please describe what has happened:	Y N DK	A7
... been concerned about your child's breathing during sleep?	Y N DK	A8
... had to shake your sleeping child to get him or her to breathe, or wake up and breathe?	Y N DK	A9
... seen your child wake up with a snorting sound?	Y N DK	A11
DOES YOUR CHILD ...		
... have restless sleep?	Y N DK	A12
... describe restlessness of the legs when in bed?	Y N DK	A13
... have "growing pains" (unexplained leg pains)?	Y N DK	A13a
... have "growing pains" that are worst in bed?	Y N DK	A13b
WHILE YOUR CHILD SLEEPS, HAVE YOU SEEN ...		
... brief kicks of one leg or both legs?	Y N DK	A14
... repeated kicks or jerks of the legs at regular intervals (i.e., about every 20 to 40 seconds)?	Y N DK	A14a
AT NIGHT, DOES YOUR CHILD USUALLY ...		
... become sweaty, or do the pajamas usually become wet with perspiration?	Y N DK	A15
... get out of bed (for any reason)?	Y N DK	A16

... get out of bed to urinate? If so, how many times each night, on average?	Y N DK _____ times	A17 A17a
Does your child usually sleep with the mouth open?	Y N DK	A21
Is your child's nose usually congested or "stuffed" at night?	Y N DK	A22
Do any allergies affect your child's ability to breathe through the nose?	Y N DK	A23
DOES YOUR CHILD ...		
... tend to breathe through the mouth during the day?	Y N DK	A24
... have a dry mouth on waking up in the morning?	Y N DK	A25
... complain of an upset stomach at night?	Y N DK	A27
... get a burning feeling in the throat at night?	Y N DK	A29
... grind his or her teeth at night?	Y N DK	A30
... occasionally wet the bed?	Y N DK	A32
Has your child ever walked during sleep ("sleep walking")?	Y N DK	A33
Have you ever heard your child talk during sleep ("sleep talking")?	Y N DK	A34
Does your child have nightmares once a week or more on average?	Y N DK	A35
Has your child ever woken up screaming during the night?	Y N DK	A36
Has your child ever been moving or behaving, at night, in a way that made you think your child was neither completely awake nor asleep? If so, please describe what has happened:	Y N DK	A37
Does your child have difficulty falling asleep at night?	Y N DK	A40
How long does it take your child to fall asleep at night? (a guess is O.K.)	_____ minutes	A41
At bedtime does your child usually have difficult "routines" or "rituals," argue a lot, or otherwise behave badly?	Y N DK	A42
DOES YOUR CHILD ... ... bang his or her head or rock his or her body when going to sleep?	Y N DK	A43
... wake up more than twice a night on average?	Y N DK	A44
... have trouble falling back asleep if he or she wakes up at night?	Y N DK	A45

... wake up early in the morning and have difficulty going back to sleep?	Y N DK	A46
Does the time at which your child goes to bed change a lot from day to day?	Y N DK	A47
Does the time at which your child gets up from bed change a lot from day to day?	Y N DK	A48
WHAT TIME DOES YOUR CHILD USUALLY ...		
... go to bed during the week?		A49
... go to bed on the weekend or vacation?		A50
... get out of bed on weekday mornings?		A51
... get out of bed on weekend or vacation mornings?		A52

B. Daytime behavior and other possible problems:		Office Use Only
DOES YOUR CHILD ...		
... wake up feeling unrefreshed in the morning?	Y N DK	B1
... have a problem with sleepiness during the day?	Y N DK	B2
... complain that he or she feels sleepy during the day?	Y N DK	B3
Has a teacher or other supervisor commented that your child appears sleepy during the day?	Y N DK	B4
Does your child usually take a nap during the day?	Y N DK	B5
Is it hard to wake your child up in the morning?	Y N DK	B6
Does your child wake up with headaches in the morning?	Y N DK	B7
Does your child get a headache at least once a month, on average?	Y N DK	B8
Did your child stop growing at a normal rate at any time since birth? If so, please describe what happened:	Y N DK	B9
Does your child still have tonsils? If not, when and why were they removed?:	Y N DK	B10
HAS YOUR CHILD EVER ...		
... had a condition causing difficulty with breathing?	Y N DK	B11

If so, please describe:		
... had surgery? If so, did any difficulties with breathing occur before, during, or after surgery?	Y N DK Y N DK	B12 B12a
... become suddenly weak in the legs, or anywhere else, after laughing or being surprised by something?	Y N DK	B13
... felt unable to move for a short period, in bed, though awake and able to look around?	Y N DK	B15
Has your child felt an irresistible urge to take a nap at times, forcing him or her to stop what he or she is doing in order to sleep?	Y N DK	B16
Has your child ever sensed that he or she was dreaming (seeing images or hearing sounds) while still awake?	Y N DK	B17
Does your child drink caffeinated beverages on a typical day (cola, tea, coffee)? If so, how many cups or cans per day?	Y N DK _____ cups	B18 B18a
Does your child use any recreational drugs? If so, which ones and how often?:	Y N DK	B19
Does your child use cigarettes, smokeless tobacco, snuff, or other tobacco products? If so, which ones and how often?:	Y N DK	B20
Is your child overweight? If so, at what age did this first develop?	Y N DK _____ years	B22 B22a
Has a doctor ever told you that your child has a high-arched palate (roof of the mouth)?	Y N DK	B23
Has your child ever taken Ritalin (methylphenidate) for behavioral problems?	Y N DK	B24
Has a health professional ever said that your child has attention-deficit disorder (ADD) or attention-deficit/hyperactivity disorder (ADHD)?	Y N DK	B25

THANK YOU!

PDSS Questionnaire (To be completed by the patient)

Patient Name:_____ **Date:**_____

Please answer the following questions as best you can. Circle one choice per question.

1. How often do you fall asleep or get drowsy during class periods?

□ Always □Frequently □Sometimes □Seldom □Never

2. How often do you get sleepy or drowsy while doing your homework?

□ Always □Frequently □Sometimes □Seldom □Never

3. Are you usually alert most of the day?

□ Always □Frequently □Sometimes □Seldom □Never

4. How often are you ever tired and grumpy during the day?

□ Always □Frequently □Sometimes □Seldom □Never

5. How often do you have trouble getting out of bed in the morning?

□ Always □Frequently □Sometimes □Seldom □Never

6. How often do you fall back to sleep after being awakened in the morning?

□ Always □Frequently □Sometimes □Seldom □Never

7. How often do you need someone to awaken you in the morning?

□ Always □Frequently □Sometimes □Seldom □Never

8. How often do you think that you need more sleep?

□ Always □Frequently □Sometimes □Seldom □Never