Thank you for choosing The Center for Sleep Medicine, a department of Berkeley Medical Center.

Enclosed you will find a sleep questionnaire and a 2 week sleep diary for your child. Please complete both and bring with you on your child's schedule appointment.

We look forward to seeing you.

Patient's Name: _____ Date of Birth: _____
Patient's Height: _____ Patient's Weight: _____
Date of Sleep Study Appointment: _____

1. At what email address would you like to be contacted? (THIS IS NOT REQUIRED) _____

2. May we contact you by email and discuss medical information?
   - O Yes, I consent to have email sent to me that may contain personal health information.
   - O No, Do not email me with any personal health information.
   - O I have questions before I make a decision.

3. Cell Phone Number: (THIS IS NOT REQUIRED) _____

4. Do you give us approval to text information?
   - O Yes
   - O No
   - O I have questions before I make a decision.

5. Other Phone Number: (THIS IS NOT REQUIRED) _____

6. Primary Care Doctor's Name: _____

7. Referring Doctor's Name: _____

8. What are your concerns about your child's sleep? _____

9. When did the problem start? _____

10. Do you think the problem is getting better, getting worse, or staying about the same? (circle one)

11. Describe how the problem has changed: _____
_____

12. What have you tried to help your child's sleep problem? _____
_____

13. On weekdays:
Bedtime is: _____
How long does is take your child to fall asleep: _____
What time does your child wake up on weekdays? _____

14. Is your child difficult to awaken on the weekdays?
   - O Yes
   - O No
   - O Sometimes

O Never

Other description of awaken behavior: _____

15. On weekends:

Bedtime is: _____

How long does is take your child to fall asleep: _____

What time does your child wake up on weekends? _____

16. Is your child difficult to awaken on the weekends?

O Yes
O No
O Sometimes
O Never

Other description of awaken behavior: _____

17. Check the following if the answer is yes:

O Needs to be fed to fall asleep
O Needs to be rocked to sleep
O Needs someone else in the room
O Can only fall asleep in your bed
O Watches TV or video to fall asleep
O Plays on computer at bedtime
O Plays video games at bedtime
O Listens to music at bedtime
O Reads a story at bedtime
O Takes bath/shower at bedtime
O Says prayer at bedtime
O Needs favorite toy to fall asleep

Other: _____

18. Who usually puts your child to bed?

O Mother
O Father
O Both parents
O Sibling
O Babysitter/Nanny
O Goes to bed without anyone

Other: _____

19. How long does your child's bedtime routine usually take? _____ (specify minutes or hours)

20. Does your child share a bedroom with someone?

O Yes
O No

If yes, Who? _____

21. Does your child have his/her own bed?

O Yes
O No

22. What kind of bed does your child have or sleep in?

O Crib
O Twin
O Full
O Queen
O Bunk bed
O Water bed
O Your bed
O Other: _____

O King

23. Where does your child usually fall asleep?
- O Own bed
- O Parent's bed
- O Sibling's bed
- O Other: _____

24. Where does your child sleep most of the night?
- O Own bed
- O Parent's bed
- O Sibling's bed
- O Other: _____

25. Where does your child usually wake up?
- O Own bed
- O Parent's bed
- O Sibling's bed
- O Other: _____

26. Check the following if the answer is yes:
- O Do pets sleep on your child's bed?
- O Is there a TV or computer in your child's bedroom?
- O Does your child read or listen to music in bed?
- O Does your child feels safe in his/her bedroom?

27. Check the following:

Are lights on during the night?	O Yes	O No
Does your child go to bed at the same time every night?	O Yes	O No
Does your child have difficulty falling asleep at night?	O Yes	O No
Does your child wake up during the night?	O Yes	O No
Does your child have difficulty falling back to sleep?	O Yes	O No
Does your child appear sleepy during the day?	O Yes	O No
Does your child take a nap during the day?	O Yes	O No
Does your child appear rested after taking a nap?	O Yes	O No

28. How does your child spend in the bedroom before going to sleep? _____ (specify minutes or hours)

29. If your child suffers with daytime sleepiness, what do you think is the cause? _____
_____

30. If your child takes naps during the day:
- How many naps are taken per day? _____
- How long is a usual nap? _____
- Where does your child nap? _____

31. If your child wakes up through the night, does he/she have difficulty falling back to sleep? _____
- How many times does your child wake up through the night? _____
- How long does it take your child to fall back to sleep? _____

What do you think wakes your child up throughout the night? _____

32. If your child has difficulty falling asleep at night, what do you think is the cause? _____
_____

33. Please check if your child has any of the following symptoms:

- O Snoring
- O Wakes up gasping for air/choking
- O Stops breathing during sleep
- O Struggles to breath during sleep
- O Shortness of breath or coughing that is worse at night
- O Restless sleep
- O Sweats excessively while asleep
- O Wets the bed while asleep
- O Cannot sleep on his/her back
- O Strange sleeping positions
- O Grinds teeth while asleep
- O "Acts out" dreams
- O Frequent nightmares
- O Frequent sleepwalking
- O Frequent talking in his/her sleep
- O Falls asleep in odd situations or places
- O Cannot keep his/her legs still prior to falling asleep or when sleeping
- O Has an irresistible need to move his/her legs when lying down or sitting
- O Wake up with heartburn or a sour, stomach-acid taste (acid reflux or indigestion)
- O Wakes up with a sore throat
- O Wakes up with heart beating fast or missing beats
- O Wakes up confused or disoriented
- O Wakes up with headaches
- O Wakes up with nausea or wanting to vomit
- O Wakes up with a dry mouth
- O Large tonsils
- O Nasal congestion at night
- O Difficulty falling asleep due to pain

- O Prefers to sleep with parents
- O Refuses to go to bed
- O Makes excuses to get out of bed at night
- O Problems with friendships or social interactions because of sleepiness
- O Problems with learning because of sleepiness
- O Problems with concentration and attention because of sleepiness
- O Fears about sleep, about his/her bedroom, or the dark
- O Difficulty falling asleep due to sadness or depression
- O Difficulty falling asleep due to being worried or anxious
- O Angry or emotional
- O Suddenly falls asleep without warning
- O "Growing pains"
- O Anger or hyperactive outburst that may be related to sleepiness
- O Has seizures while sleeping
- O Claustrophobia
- O Recent weight gain

34. Has your child ever experienced a sudden weakness (not dizziness) in the knees, neck, or arms when he/she is startled or laughing? _____

35. Does your child have regular meal times?

- O Yes
- O No

36. What time does your child usually eat? (be sure to write am or pm for each meal)

Breakfast _____
Lunch _____
Dinner _____
Snacks _____

37. Within two hours of bedtime:

How many ounces does your child drink? _____
What does your child drink? _____
How much does your child eat? _____

38. Does your child get up to eat in the middle of the night?

- O Yes
- O No

39. Does your child drink any beverages containing CAFFEINE? (Please check all that apply)

- O Coffee
- O Hot tea
- O Iced tea
- O Caffeinated soda (including mountain dew, Dr. Pepper, Coke, Pepsi, Diet Soda)
- O Energy drinks
- O None
- O Other: _____

40. How many hours of TV does your child watch in a…

Day? _____

Week? _____

41. How many hours of Video Games does your child play in a…

Day? _____

Week? _____

42. How many hours does your child spend on a Computer in a…

Day? _____

Week? _____

43. What does your child do for physical activity or exercise? _____

_____

44. **PLEASE RATE HOW SLEEPY YOUR CHILD FEELS DURING THE DAY.** How likely is your child to DOZE OFF or FEEL SLEEPY (not just tired or fatigued) in the following situations? This refers to how sleepy he or she has been RECENTLY (such as in the last two weeks). If your child has not been in the following situations recently, try to imagine how sleepy he or she WOULD feel in these situations. **Use the following scale to choose the most appropriate number in each situation:** (Circle one)

0 = My child would NEVER doze off
1 = My child would have a SLIGHT CHANCE of dozing off
2 = My child would have a MODERATE CHANCE of dozing off
3 = My child would have a HIGH CHANCE of dozing off

In school	0	1	2	3
After school	0	1	2	3
Sitting quietly in a public place (such as in a movie classroom, or church)	0	1	2	3
As a passenger in a car	0	1	2	3
Lying down to rest in the afternoon	0	1	2	3

Playing quietly with friends	0	1	2	3
Sitting quietly after lunch	0	1	2	3
Watching TV	0	1	2	3

45. At what age did your child… (please answer in years and/or months)

Walk? _____

Talk? _____

46. Can your child: (check all that apply)

- O Point to body parts?
- O Know his/her age?
- O Say the alphabet?
- O Count? How high? _____
- O Multiple/Divide?
- O Know colors?
- O Write name?
- O Read at grade level?

47. Check the following:

Is your child in school?	O Yes	O No
Has your child ever been held back?	O Yes	O No
Is your child in special education classes?	O Yes	O No
Does your child have a learning problem or disability?	O Yes	O No
Is your child homeschooled?	O Yes	O No

48. Have you, your child's teacher, or any other adult witnessed or reported any of the following in your child:

- O Too sleepy
- O Outburst of anger
- O Sad/Blue
- O Falls asleep in class
- O Daydreams
- O Disruptive in class
- O Grades are falling
- O Aggressive behavior
- O Outburst of hyperactivity
- O Short attention span
- O Stares into space
- O Does not follow instructions
- O Appears to get weak or collapse when angry, laughing or crying
- O Other: _____

49. How are your child's grades this year?

- O Excellent
- O Good

O Average
O Poor
O Not in school

50. How were your child's grades last year?
O Excellent
O Good
O Average
O Poor
O Not in school

51. Does your child have behavior problems? _____ If yes, please describe: _____
_____

52. Has your child been late to school because of difficulty waking up in the morning? _____
If yes, How many times this year? _____
How many times last year? _____

53. Does your child take any medicines or herbs (prescribed or over-the-counter) to help him/her go to sleep? _____
If yes, Please list name, dose and frequency: _____

54. Does your child take any medicines or herbs (prescribed or over-the-counter) to help him/her stay awake? _____
If yes, Please list name, dose and frequency: _____

55. Please list any allergies:
Environmental (food, grass, latex, etc.): _____
Medications: _____

56. Please list ALL medications (including over-the-counter and nutritional supplements) that your child is CURRENTLY taking: _____
_____
_____

57. Does your child HAVE NOW or HAD IN THE PAST any of the following? (Check all that apply)

O ADD or ADHD
O Acid reflux
O Adenoids removed
O ALTE or near-SIDS
O Anemia
O Anxiety
O Asthma
O Bedwetting
O Behavior problems
O Born premature
O Brain injury
O Cancer
O Chronic pain
O Cystic fibrosis
O Depression
O Hearing problems
O Heart murmur
O Heart problems
O Heart surgery
O Head injury
O High blood pressure
O High cholesterol
O HIV and/or AIDS
O Injury to nose
O Kidney problems
O Mental illness
O Needs/has glasses
O Overweight or obesity
O Pneumonia
O Problems at birth

- O Developmental delay
- O Diabetes
- O Ear tubes
- O Environmental allergies
- O Fainting
- O Febrile convulsions
- O Frequent ear infections
- O Headaches
- O Poor appetite or picky eater
- O Seasonal allergies
- O Seizures or seizure disorder
- O Sinus problems
- O Slow growth
- O Speech problems
- O Thyroid problems
- O Tonsillectomy

58. Please list ANY other medical problems not listed above: _____

59. Please list ANY operations or hospitalizations: _____

60. Was your child born:
- O Full term
- O Premature

61. What was your child's birth weight? _____

62. Please describe any complications with the child's pregnancy, labor, or birth: _____
_____

63. Does your child have any BLOOD RELATIVES who HAVE or HAD IN THE PAST any of the following? (Check all that apply)
- O ADD or ADHD
- O Alzheimer's disease
- O Allergies
- O Anemia
- O Anxiety
- O Asthma
- O Bipolar disorder
- O Brain tumor
- O Cancer or leukemia
- O Learning problems
- O Depression
- O Kidney disease
- O Loud snoring
- O Mental illness
- O Narcolepsy
- O Obesity
- O Restless leg syndrome
- O Schizophrenia
- O SIDS or crib death
- O Sleep apnea
- O Sleep problems
- O Sleepwalking

O Diabetes
O Headaches/Migraines
O Hyperactivity
O Emphysema/COPD
O Epilepsy/Seizures
O Excessive daytime sleepiness
O Heart disease
O High blood pressure
O High cholesterol
O Insomnia
O Snoring
O Stroke/Brain hemorrhage
O Thyroid disease
O Tuberculosis
O Other family medical conditions: _____
_____

64. List the name and age of all siblings:

Name: _____ Age: _____
Name: _____ Age: _____
Name: _____ Age: _____
Name: _____ Age: _____
Name: _____ Age: _____

65. List name and relationship to patient of everyone living in the home:

Name: _____ Relationship: _____
Name: _____ Relationship: _____
Name: _____ Relationship: _____
Name: _____ Relationship: _____
Name: _____ Relationship: _____
Name: _____ Relationship: _____
Name: _____ Relationship: _____

66. Check the following:

Are there any smokers in the home?	O Yes	O No
Are there any guns in the home?	O Yes	O No
Is there anyone in the home who has a problem with drugs or alcohol?	O Yes	O No
Are there any pets in the home?	O Yes	O No

67. Please check ANY problems that the child has experienced in the last TWO WEEKS:

O Trouble seeing
O Eye irritation or discomfort
O Ear pain
O Nosebleeds
O Stuffy or congested nose
O Difficulty swallowing
O Sore throat
O Urinary tract infections
O Abnormal bleeding
O Easy bruising
O Infections
O Rash
O Skin sores or lesions
O Eczema

- O Sinus Problems
- O Nasal speech
- O Neck stiffness or pain
- O Swollen neck glands
- O Chest pain
- O Tightness/pressure in chest
- O Skipped heart beats
- O Poor circulation
- O Back or joint pain
- O Clumsy walking
- O Growing pains
- O Wheezing
- O Shortness of breath
- O Nighttime cough
- O Acid reflux/heartburn
- O Nausea/Vomiting
- O Frequent stomach aches
- O Physical or emotional abuse
- O Headaches
- O Dizziness
- O Fainting
- O Tics
- O Staring spells
- O Underweight
- O Overweight
- O Aggressive/Angry a lot
- O Anxiety or panic attacks
- O Cries easily
- O Sad or blue mood/depression
- O Fidgety
- O Difficulty completing tasks
- O Easily distracted
- O Easily frustrated
- O Doesn't play like other kids
- O Poor eye contact

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