Helen DeVos children's hospital
OF SPECTRUM HEALTH

Questionnaire
NEW PATIENT, SLEEP - PEDIATRIC PULMONARY AND SLEEP MEDICINE CLINIC

Patient Name
DOB
MRN
Physician
FIN

Patient name _____ Date of birth _____
Sex: ☐ Male ☐ Female Age _____ Grade _____ Appointment date _____
Referring Physician _____
Mother's name/Legal guardian _____ Occupation _____
Father's name/Legal guardian _____ Occupation _____
Briefly describe reason for the visit _____

MEDICINES

List all medicines your child is currently taking, including non-prescription or herbal therapies:

MEDICINE	DOSE	HOW OFTEN TAKEN

PREFERRED PHARMACY

Name _____
Phone _____
Address _____

PREFERRED MEDICAL EQUIPMENT COMPANY

Name _____
Phone _____
Address _____

BIRTH INFORMATION

Birth weight _____ Gestational age _____
Delivery method _____
Additional birth information _____

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DO NOT MARK BELOW THIS LINE BARCODE ZONE DO NOT MARK BELOW THIS LINE

X15301

GENERAL SLEEP INFORMATION

SLEEP HISTORY

Does your child have a regular bedtime routine? ☐ No ☐ Yes

Does your child have his/her own bed? ☐ No ☐ Yes

Does your child have his/her own bedroom? ☐ No ☐ Yes

Is a parent present when your child falls asleep? ☐ No ☐ Yes

Where does your child usually fall asleep?
☐ His/her room, own bed (alone) ☐ Parent room, own bed ☐ Parent room, parent bed
☐ Sibling room, own bed ☐ Sibling room, sibling bed ☐ Other _____

Where does your child usually spend most of the night?
☐ His/her room, own bed (alone) ☐ Parent room, own bed ☐ Parent room, parent bed
☐ Sibling room, own bed ☐ Sibling room, sibling bed ☐ Other _____

Where does your child usually wake up in the morning at?
☐ His/her room, own bed (alone) ☐ Parent room, own bed ☐ Parent room, parent bed
☐ Sibling room, own bed ☐ Sibling room, sibling bed ☐ Other _____

Who is your child usually put to bed by: ☐ Mother ☐ Father ☐ Both parents ☐ Self ☐ Other _____

Does your child resist going to bed? ☐ No ☐ Yes If yes, do you feel this is a problem? ☐ No ☐ Yes

Does your child have difficulty falling asleep? ☐ No ☐ Yes If yes, do you feel this is a problem? ☐ No ☐ Yes

Does your child awaken during the night? ☐ No ☐ Yes If yes, do you feel this is a problem? ☐ No ☐ Yes

After nighttime waking, child has difficulty falling back to sleep? ☐ No ☐ Yes If yes, do you feel this is a problem? ☐ No ☐ Yes

Is your child difficult to wake up in the morning? ☐ No ☐ Yes If yes, do you feel this is a problem? ☐ No ☐ Yes

Is your child is a poor sleeper? ☐ No ☐ Yes If yes, do you feel this is a problem? ☐ No ☐ Yes

SLEEP SCHEDULE

What is the amount of time the child spends in their bedroom before going to sleep? _____ minutes

What is the amount of time your child sleeps during a 24-hour period on weekdays? ___ hours ___ minutes

What is your child's usual bedtime on weekday nights? _____ : _____

What is your child's usual waketime on weekday nights? _____ : _____

What is the amount of time your child sleeps during a 24-hour period on weekends and holidays? ___ hours ___ minutes

What is your child's usual bedtime on weekend/holiday nights? _____ : _____

What is your child's usual waketime on weekday/holiday nights? _____ : _____

What is in the number of days per week your child has a nap? _____ days per week

If your child naps, write in the usual nap time(s): Nap 1: ___ : ___ ☐AM/☐PM to ___ : ___ ☐AM/☐PM

Nap 2: ___ : ___ ☐AM/☐PM to ___ : ___ ☐AM/☐PM

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NEW PATIENT, SLEEP - PEDIATRIC PULMONARY AND SLEEP MEDICINE CLINIC *(CONTINUED)*

Patient Name
DOB
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Physician
FIN

CURRENT SLEEP SYMPTOMS (*Check the appropriate column for each symptom)*

	Never	Not often (less than 1 day/week)	Sometimes (1 to 2 days/week)	Often (3 to 5 days/week)	Always (6 to 7 days/week)	Unsure
Difficulty breathing during sleep	☐	☐	☐	☐	☐	☐
Stops breathing during sleep	☐	☐	☐	☐	☐	☐
Snores	☐	☐	☐	☐	☐	☐
Restless sleep	☐	☐	☐	☐	☐	☐
Sweating during sleep	☐	☐	☐	☐	☐	☐
Daytime sleepiness	☐	☐	☐	☐	☐	☐
Nightmares	☐	☐	☐	☐	☐	☐
Sleepwalking	☐	☐	☐	☐	☐	☐
Sleeptalking	☐	☐	☐	☐	☐	☐
Screaming during sleep	☐	☐	☐	☐	☐	☐
Kicks legs during sleep	☐	☐	☐	☐	☐	☐
Wakes up at night	☐	☐	☐	☐	☐	☐
Gets out of bed at night	☐	☐	☐	☐	☐	☐
Trouble staying in their bed	☐	☐	☐	☐	☐	☐
Resists going to bed	☐	☐	☐	☐	☐	☐
Teeth grinding	☐	☐	☐	☐	☐	☐
Wets bed	☐	☐	☐	☐	☐	☐
Uncomfortable feeling in legs (ie. "creepy-crawly)	☐	☐	☐	☐	☐	☐
Trouble getting up in the morning	☐	☐	☐	☐	☐	☐
Falls asleep in school	☐	☐	☐	☐	☐	☐
Naps after school	☐	☐	☐	☐	☐	☐
Daytime sleepiness	☐	☐	☐	☐	☐	☐
Feels weak or loses control of their with strong emotions	☐	☐	☐	☐	☐	☐
Reports feeling unable to move when falling asleep or upon waking up	☐	☐	☐	☐	☐	☐
Sees frightening visual images before falling asleep or upon waking up	☐	☐	☐	☐	☐	☐
Morning headaches	☐	☐	☐	☐	☐	☐

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NEW PATIENT, SLEEP - PEDIATRIC PULMONARY AND SLEEP MEDICINE CLINIC *(CONTINUED)*

MEDICAL HISTORY

Has your child ever had any of the following?

Abnormal chest x-ray	☐ No ☐ Yes	Frequent ear infections	☐ No ☐ Yes
Allergies	☐ No ☐ Yes	Gastrointestinal reflux	☐ No ☐ Yes
Anemia	☐ No ☐ Yes	Heart problems	☐ No ☐ Yes
Asthma	☐ No ☐ Yes	Hives	☐ No ☐ Yes
Bronchiectasis	☐ No ☐ Yes	High blood pressure	☐ No ☐ Yes
Chronic bronchitis	☐ No ☐ Yes	Neuromuscular problem	☐ No ☐ Yes
Coughing up blood	☐ No ☐ Yes	Obesity	☐ No ☐ Yes
Developmental delay	☐ No ☐ Yes	Pneumonia	☐ No ☐ Yes
Diabetes	☐ No ☐ Yes	Poor weight gain	☐ No ☐ Yes
Down's syndrome	☐ No ☐ Yes	Premature	☐ No ☐ Yes
Dysphagia	☐ No ☐ Yes	Pulmonary embolism/blood clot	☐ No ☐ Yes
Epilepsy/Seizures	☐ No ☐ Yes	Sleep apnea	☐ No ☐ Yes
Eczema	☐ No ☐ Yes	Tuberculosis	☐ No ☐ Yes

Other medical history _____

_____

List any other doctors or therapists involved in your child's care _____

Allergist _____

SURGICAL HISTORY WITH DATES

Adenoidectomy?	☐ No ☐ Yes on _____	Bronchoscopy?	☐ No ☐ Yes on _____
Circumcision?	☐ No ☐ Yes on _____	Ear tubes?	☐ No ☐ Yes on _____
Gastric tube?	☐ No ☐ Yes on _____	Lobectomy?	☐ No ☐ Yes on _____
Nissen fundoplication?	☐ No ☐ Yes on _____	Sinus surgery?	☐ No ☐ Yes on _____
Tonsillectomy?	☐ No ☐ Yes on _____	Other? _____	☐ No ☐ Yes on _____

FAMILY HISTORY

RELATIONSHIP M=Maternal P=Paternal	**NAME**	**AGE**	Asthma	Allergies	GERD	Heart Disease	Depression	Hypertension	Stroke	Diabetes	ADHD	Obstructive Sleep Apnea	Snoring	Restless leg syndrome	Narcolepsy	Epilepsy
Mother																
Father																
Sister																
Brother																
M Aunt																
M Uncle																
P Aunt																
P Uncle																
M Grandmother																
M Grandfather																
P Grandmother																
P Grandfather																
Other																

OTHER SOCIAL HISTORY

Does your child live with his/her parents(s)? ☐ No ☐ Yes Who lives in the home? _____

Is your child adopted? ☐ No ☐ Yes If yes, at what age? _____

Name of person completing the form _____

DATE _____ Signature _____