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HAWAIʻI PACIFIC HEALTH | KAPIʻOLANI MEDICAL CENTER FOR WOMEN & CHILDREN
CREATING A HEALTHIER HAWAIʻI

# PEDIATRIC SLEEP MEDICINE QUESTIONNAIRE

Today's Date:_____
Name: _____
Sex: _____Date of Birth: _____Grade in school_____
Person completing form and relationship to patient:_____

**<u>SECTION 1:</u> Please answer these questions regarding the behavior of your child during sleep and wakefulness. The questions apply to how your child acts in general during the past month, not necessarily during the past few days since these may not have been typical if your child has not been well. 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."**

1. WHILE SLEEPING, DOES YOUR CHILD:

| | | | |
|---|---|---|---|
| Snore more than half the time? | Y ☐ | N ☐ | DK ☐ |
| Always snore? | Y ☐ | N ☐ | DK ☐ |
| Snore loudly? | Y ☐ | N ☐ | DK ☐ |
| Have "heavy" or loud breathing? | Y ☐ | N ☐ | DK ☐ |
| Have trouble breathing, or struggle to breathe? | Y ☐ | N ☐ | DK ☐ |

2. HAVE YOU EVER SEEN YOUR CHILD STOP BREATHING DURING THE NIGHT?
Y ☐ N ☐ DK ☐

3. DOES YOUR CHILD:

| | | | |
|---|---|---|---|
| Tend to breathe through the mouth during the day? | Y ☐ | N ☐ | DK ☐ |
| Have a dry mouth on waking up in the morning? | Y ☐ | N ☐ | DK ☐ |
| Occasionally wet the bed? | Y ☐ | N ☐ | DK ☐ |

4. HAS A TEACHER OR OTHER SUPERVISOR COMMENTED THAT YOUR CHILD APPEARS SLEEPY DURING THE DAY?
Y ☐ N ☐ DK ☐

5. IS IT HARD TO WAKE YOUR CHILD UP IN THE MORNING?
Y ☐ N ☐ DK ☐

6. DOES YOUR CHILD WAKE UP WITH HEADACHES IN THE MORNING?…..
Y ☐ N ☐ DK ☐

7. DID YOUR CHILD STOP GROWING AT A NORMAL RATE AT ANY TIME SINCE BIRTH?
Y ☐ N ☐ DK ☐

8. IS YOUR CHILD OVERWEIGHT? Y ☐ N ☐ DK ☐

9. THIS CHILD OFTEN:

| | | | |
|---|---|---|---|
| Does not seem to listen when spoken to directly. | Y ☐ | N ☐ | DK ☐ |
| Has difficulty organizing tasks and activities. | Y ☐ | N ☐ | DK ☐ |
| Is easily distracted by extraneous stimuli. | Y ☐ | N ☐ | DK ☐ |
| Fidgets with hands or feet or squirms in seat. | Y ☐ | N ☐ | DK ☐ |
| Is "on the go" or often acts as if "driven by a motor". | Y ☐ | N ☐ | DK ☐ |
| Interrupts or intrudes on others (eg., butts into conversations or games). | Y ☐ | N ☐ | DK ☐ |

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**SECTION 2: Please read the question below and then circle the phrase that best applies to this child.**

A. When he/she tries to relax in the evening or sleep at night, does he/she move their legs a lot and cannot
seem to get comfortable? Or complain of an uncomfortable sensation in his/her legs at night?
Unknown ☐ Yes ☐ No ☐

B. Does this child kick their legs at night?
Unknown ☐ Yes ☐ No ☐

C. Does this child have the sudden urge to fall asleep outside of their normal bedtime?
Unknown ☐ Yes ☐ No ☐

D. Does this child ever feel like he/she is unable to move their arms or legs for a short period, in bed, though awake and able to look around?
Unknown ☐ Yes ☐ No ☐

E. Does this child say that he/she feels weak or unable to move when laughing, angry or in other emotional situations?
Unknown ☐ Yes ☐ No ☐

F. Does this child say that he/she sees images when waking up or falling asleep, is as if he/she were dreaming?
Unknown ☐ Yes ☐ No ☐

G. Does this child move around a lot in bed?
Unknown ☐ Yes ☐ No ☐

H. Does this child have nightmares once a week or more on average?
Unknown ☐ Yes ☐ No ☐

I: Does this child wake up screaming at night?
Unknown ☐ Yes ☐ No ☐

I. Does this child grind their teeth at night?
Unknown ☐ Yes ☐ No ☐

J. Does this child seem to feel anxious about their sleep?
Unknown ☐ Yes ☐ No ☐

K. Does this child have pain or discomfort at night?
Unknown ☐ Yes ☐ No ☐

M. Does he/she have acid reflux at night?
Unknown ☐ Yes ☐ No ☐

N. Does this child have any abnormal movements at night (i.e. sleep walking, sleep talking, sleep eating)?
Unknown ☐ Yes ☐ No ☐

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**SECTION 3: Please answer the following questions as appropriate.**

1. Has this child had a sleep study in the past? ❑ Yes ❑ No

2. Does this child drink caffeine? If yes, how many times a week do they drink caffeine?
   ❑ Never ❑ 1-3 times ❑ 4-5 times ❑ 6-7 times

3. Does this child take a prescription medicine or over the counter medicine or herbal product for sleep?
   ❑ Yes ❑ No
   If yes what is the name of the medicine/product _____

4. Does this child take a product stay awake during the daytime? ❑ Yes ❑ No
   If yes what is the name of the product _____

5. Has your child ever taken Ritalin (methylphenidate) for behavioral problems?
   ☐ Unknown ☐ Yes ☐ No

6. Has a health professional ever said that your child has attention-deficit disorder (ADD) or attention-deficit/hyperactivity disorder (ADHD)?
   ☐ Unknown ☐ Yes ☐ No

7. Does this child use recreational drugs? ❑ Yes ❑ No
   If yes what is the name of the drug _____

8. Does this child still have tonsils? ❑ Yes ❑ No
   If no, when and why were they removed?_____

9. How many times does this child nap a day?
   ❑ Never ❑ 1-3 times ❑ 4-5 times ❑ Daily

10. At bedtime does this child have difficult “routines” or “rituals,” argue a lot, or other wise behave badly?
    ☐ Unknown ☐ Yes ☐ No

11. On weekdays he/she goes to bed at _____PM and wakes up at _____ AM.

12. On weekends he/she goes to bed at _____PM and wakes up at _____ AM.

13. On average it takes him/her the following amount of time to fall asleep:
    ❑ <5 minutes ❑ 5-10 minutes ❑ 10-20 minutes ❑ 20-30 minutes ❑ 30-60minutes
    ❑ More than 60 minutes

14. This child wakes up _____ times a night for _____ minutes before falling back to sleep.

15. This child wakes up in the middle of the night to_____

16. Does this child do other activities (i.e. read a book, watch TV, play on the phone) while in bed?
    ❑ Yes ❑ No
    If yes please list the activities: _____

17. The follow best describes this child’s exercise level:
    ❑ Little or no exercise ❑ Exercise at least 3x a week ❑ Exercise at least 6-7x a week

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18. Please list any sleep disorders diagnosed or suspected by a physician in your child. For each problem, please list the date it started and whether or not it is still present.

_____

_____

_____

_____

19. Please list any psychological, psychiatric, emotional, or behavioral problems diagnosed or suspected by a physician in your child. For each problem, please list the date it started and whether or not it is still present.

_____

_____

_____

_____

20. Please list any sleep or behavior disorders diagnosed or suspected in *your child's* brothers, sisters, or parents. Common sleep conditions include: Restless leg syndrome, Obstructive sleep apnea, Insomnia, Parasomnia (sleepwalking/talking/eating) or Narcolepsy.

| Relative | Condition |
|---|---|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

21. Additional Comments: Please use the space below to print any additional comments you feel are important. Please also use this space to describe details regarding any of the above questions.

_____

_____

_____

Questionnaire was adapted from the PSQ with permission from Regents of the University of Michigan 2017.

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