



SLEEP HISTORY QUESTIONNAIRE

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

Please answer the following question based on your child's typical night of sleep.

1. What is your child's bedtime during the week?	:	
2. What is your child's bedtime during the weekend?	:	
3. How many hours of sleep does your child get on weekdays?	hours	
4. How many hours of sleep does your child get on the weekends?	hours	
5. What time does your child wake up during the week?	:	
6. What time does your child wake up during the weekend?	:	
7. Does your child take naps? If yes, how many? If yes, what time?	Yes	No
	:	
8. Does your child have a bedtime routine?	Yes	No
9. Does your child use media at night? (TV, video games, cell phone, computer)	Yes	No
10. Does your child consume caffeine?	Yes	No
11. Does your child do any of the following? Check all that apply. <input type="checkbox"/> Snore <input type="checkbox"/> Congestion <input type="checkbox"/> Pause while breathing <input type="checkbox"/> Mouth breathing		
12. Does your child have a preferred sleep position? If yes, explain: _____	Yes	No
13. Has your child had nose/throat surgery? If yes, date of surgery: _____	Yes	No
14. Does your child use a CPAP machine? If yes, what are the settings? _____	Yes	No
15. Does your child have a family history of Obstructive Sleep Apnea?	Yes	No
16. Does your child complain of abnormal feelings in his/her legs and feet?	Yes	No
17. Does your child feel the urge to move?	Yes	No
18. What time of day does your child complain?	Day	Night
19. Do the complaints increase while your child is sitting still?	Yes	No
20. Does your child jerk when sleeping at night?	Yes	No
21. Does your child have restless sleeping?	Yes	No
22. Does your child have a family history of Restless Leg Syndrome?	Yes	No
23. Does your child talk in his/her sleep?	Yes	No

**CUESTIONARIO DE ANTECEDENTES DEL SUEÑO
SLEEP HISTORY QUESTIONNAIRE**

23. ¿El niño habla dormido?	Sí	No
24. ¿El niño es sonámbulo?	Sí	No
25. ¿Su hijo tiene terrores nocturnos?	Sí	No
26. ¿El niño se ha lastimado durante la noche?	Sí	No
27. ¿El niño come durante la noche?	Sí	No
28. ¿El niño se porta mal en sus sueños?	Sí	No
29. ¿Su hijo tiene pesadillas? Si es así, ¿cuántas horas después de que se quedó dormido? Si es así, ¿cuántas pesadillas cada noche?	Sí	No
	horas	
30. ¿Su hijo tiene antecedentes familiares de sonambulismo o de terrores nocturnos?	Sí	No
31. ¿Al niño le cuesta trabajo dormirse? ¿Cuándo empezó? _____	Sí	No
32. ¿El niño se despierta durante la noche?	Sí	No
33. ¿Si se despierta, le cuesta trabajo volverse a dormir?	Sí	No
34. Describa el lugar donde duerme el niño: _____		
35. ¿El niño toma algún medicamento para dormir?	Sí	No
36. ¿El niño tiene antecedentes familiares de insomnio?	Sí	No
37. ¿El niño se queda dormido durante el día?	Sí	No
38. ¿Su hijo se siente débil o pierde el control de los músculos con emociones fuertes?	Sí	No
39. ¿El niño ve o escucha cosas que no están ahí cuando se despierta?	Sí	No
40. ¿El niño no puede moverse por cierto tiempo cuando se despierta?	Sí	No
41. ¿El niño tiene antecedentes familiares de narcolepsia?	Sí	No
42. ¿El niño ha tenido alguno de los siguientes? Marque todos los que correspondan. <input type="checkbox"/> Aumento de peso <input type="checkbox"/> Depresión <input type="checkbox"/> Ansiedad		

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24. Does your child sleep walk?	Yes	No
25. Does your child have sleep terrors?	Yes	No
26. Has your child injured himself/herself at night?	Yes	No
27. Does your child eat at night?	Yes	No
28. Does your child act out in his/her dreams?	Yes	No
29. Does your child have nightmares? If yes, how many hours after your child falls asleep? If yes, how many events each night?	Yes	No
	hours	
30. Does your child have a family history of sleepwalking or sleep terrors?	Yes	No
31. Does your child have difficulty falling asleep? When did this start? _____	Yes	No
32. Does your child awaken during the night?	Yes	No
33. If awakening, does your child have difficulty returning to sleep?	Yes	No
34. Describe where your child sleeps: _____		
35. Does your child take any medications for sleep?	Yes	No
36. Does your child have a family history of Insomnia?	Yes	No
37. Does your child fall asleep during the day?	Yes	No
38. Does your child feel weak or lose control of his/her muscles with strong emotions?	Yes	No
39. Does your child see/hear things that are not there when waking up?	Yes	No
40. Is your child unable to move for a period of time when waking up?	Yes	No
41. Does your child have a family history of Narcolepsy?	Yes	No
42. Is your child experiencing any of the following? Mark all that apply. <input type="checkbox"/> Weight gain <input type="checkbox"/> Depression <input type="checkbox"/> Anxiety		