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