Banner Health®

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?	Yes	No
If yes, how many?		
If yes, what time?	:	
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

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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?	Yes	No
If yes, how many hours after your child falls asleep?	hours	
If yes, how many events each night?		
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. ❑ Weight gain ❑ Depression ❑ Anxiety		

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