Date Form Completed: \_\_\_ \_\_\_ - \_\_\_ \_\_\_ \_\_\_ - \_\_\_ \_\_\_ \_\_\_ \_\_\_ (DD-MMM-YYYY)

School or Weekdays: [ ]  Mon [ ]  Tues [ ]  Wed [ ] Thurs [ ]  Fri

Usual Bedtime: **\_\_\_ \_\_\_ :\_\_\_ \_\_\_** [ ]  AM [ ]  PM

Time When Child Really Falls Asleep: **\_\_\_ \_\_\_ :\_\_\_ \_\_\_** [ ]  AM [ ]  PM

Usual Wake Time**\_\_\_ \_\_\_:\_\_\_ \_\_\_** [ ]  AM [ ]  PM

 Non-School or Weekends: [ ]  Mon [ ]  Tues [ ]  Wed [ ] Thurs [ ]  Fri [ ]  Sat [ ]  Sun

Usual Bedtime: **\_\_\_ \_\_\_:\_\_\_ \_\_\_**

Time When Child Really Falls Asleep: **\_\_\_ \_\_\_:\_\_\_ \_\_\_**

Usual Wake Time**\_\_\_ \_\_\_:\_\_\_ \_\_\_**

Daily Napping: \_\_\_\_\_\_\_\_\_

None: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ]  Yes

[ ]  No

Number of naps:\_\_\_\_\_\_

Hours napping: \_\_\_: \_\_\_ hrs/mins

Sleep History, Health Habits and Sleep Environment

Does the child have a regular bedtime routine?

[ ]  Yes

[ ]  No

Does the child have his/her own bedroom?

[ ]  Yes

[ ]  No

Does the child have his/her own bed?

[ ]  Yes

[ ]  No

Does your child have a TV in his own bedroom?

[ ]  Yes

[ ]  No

If YES, does your child usually fall asleep with the TV on?

[ ]  Yes

[ ]  No

[ ]  Don’t Know

Does your child drink caffeinated beverages (e.g., Coke, Pepsi, Mountain Dew, iced tea) on most days?

[ ]  Yes

[ ]  No

If YES, how many servings on an average day?

[ ]  Yes

[ ]  No

Where My Child Sleeps

Child usually falls asleep in

[ ]  Own room in own bed (alone)

[ ]  Parents’ room in own bed

[ ]  Sibling’s room in own bed

[ ]  Sibling’s room in sibling’s bed

Child sleeps most of the night in

[ ]  Own room in own bed (alone)

[ ]  Parents’ room in own bed

[ ]  Sibling’s room in own bed

[ ]  Sibling’s room in sibling’s bed

Child usually wakes in the morning in

[ ]  Own room in own bed (alone)

[ ]  Parents’ room in own bed

[ ]  Sibling’s room in own bed

[ ]  Sibling’s room in sibling’s bed

1. **Sleep Symptoms or Problems**

During the past month, which of the following symptoms or problems has your child had?

Snores

[ ]  Never (does not happen)

[ ]  Not Often (<1 night/day a week)

[ ]  Sometimes (1 to 2 nights/days a week)

[ ]  Often (3 to 5 nights/days a week)

[ ]  Always (6 to 7 nights/days a week)

[ ]  Don’t Know

[ ]  No answer

Difficulty breathing while asleep

[ ]  Never (does not happen)

[ ]  Not Often (<1 night/day a week)

[ ]  Sometimes (1 to 2 nights/days a week)

[ ]  Often (3 to 5 nights/days a week)

[ ]  Always (6 to 7 nights/days a week)

[ ]  Don’t Know

[ ]  No answer

Stops breathing during sleep

[ ]  Never (does not happen)

[ ]  Not Often (<1 night/day a week)

[ ]  Sometimes (1 to 2 nights/days a week)

[ ]  Often (3 to 5 nights/days a week)

[ ]  Always (6 to 7 nights/days a week)

[ ]  Don’t Know

[ ]  No answer

Noisy breathing

[ ]  Never (does not happen)

[ ]  Not Often (<1 night/day a week)

[ ]  Sometimes (1 to 2 nights/days a week)

[ ]  Often (3 to 5 nights/days a week)

[ ]  Always (6 to 7 nights/days a week)

[ ]  Don’t Know

[ ]  No answer

Restless sleep

[ ]  Never (does not happen)

[ ]  Not Often (<1 night/day a week)

[ ]  Sometimes (1 to 2 nights/days a week)

[ ]  Often (3 to 5 nights/days a week)

[ ]  Always (6 to 7 nights/days a week)

[ ]  Don’t Know

[ ]  No answer

Sweating when sleeping

[ ]  Never (does not happen)

[ ]  Not Often (<1 night/day a week)

[ ]  Sometimes (1 to 2 nights/days a week)

[ ]  Often (3 to 5 nights/days a week)

[ ]  Always (6 to 7 nights/days a week)

[ ]  Don’t Know

[ ]  No answer

Nightmares

[ ]  Never (does not happen)

[ ]  Not Often (<1 night/day a week)

[ ]  Sometimes (1 to 2 nights/days a week)

[ ]  Often (3 to 5 nights/days a week)

[ ]  Always (6 to 7 nights/days a week)

[ ]  Don’t Know

[ ]  No answer

Sleep walking

[ ]  Never (does not happen)

[ ]  Not Often (<1 night/day a week)

[ ]  Sometimes (1 to 2 nights/days a week)

[ ]  Often (3 to 5 nights/days a week)

[ ]  Always (6 to 7 nights/days a week)

[ ]  Don’t Know

[ ]  No answer

Sleep talking

[ ]  Never (does not happen)

[ ]  Not Often (<1 night/day a week)

[ ]  Sometimes (1 to 2 nights/days a week)

[ ]  Often (3 to 5 nights/days a week)

[ ]  Always (6 to 7 nights/days a week)

[ ]  Don’t Know

[ ]  No answer

Screaming in his/her sleep

[ ]  Never (does not happen)

[ ]  Not Often (<1 night/day a week)

[ ]  Sometimes (1 to 2 nights/days a week)

[ ]  Often (3 to 5 nights/days a week)

[ ]  Always (6 to 7 nights/days a week)

[ ]  Don’t Know

[ ]  No answer

[ ]  Never (does not happen)

[ ]  Not Often (<1 night/day a week)

[ ]  Sometimes (1 to 2 nights/days a week)

[ ]  Often (3 to 5 nights/days a week)

[ ]  Don’t Know

[ ]  No answer

Kicks or jerks legs in sleep

[ ]  Never (does not happen)

[ ]  Not Often (<1 night/day a week)

[ ]  Sometimes (1 to 2 nights/days a week)

[ ]  Often (3 to 5 nights/days a week)

[ ]  Always (6 to 7 nights/days a week)

[ ]  Don’t Know

[ ]  No answer

Uncomfortable feelings in his/her legs; creepy/crawly before falling asleep

[ ]  Never (does not happen)

[ ]  Not Often (<1 night/day a week)

[ ]  Sometimes (1 to 2 nights/days a week)

[ ]  Often (3 to 5 nights/days a week)

[ ]  Always (6 to 7 nights/days a week)

[ ]  Don’t Know

[ ]  No answer

Resists going to bed at bedtime

[ ]  Never (does not happen)

[ ]  Not Often (<1 night/day a week)

[ ]  Sometimes (1 to 2 nights/days a week)

[ ]  Often (3 to 5 nights/days a week)

[ ]  Always (6 to 7 nights/days a week)

[ ]  Don’t Know

[ ]  No answer

Trouble falling asleep

[ ]  Never (does not happen)

[ ]  Not Often (<1 night/day a week)

[ ]  Sometimes (1 to 2 nights/days a week)

[ ]  Often (3 to 5 nights/days a week)

[ ]  Always (6 to 7 nights/days a week)

[ ]  Don’t Know

[ ]  No answer

Feels like s/he can’t move arms or legs when falling asleep

[ ]  Never (does not happen)

[ ]  Not Often (<1 night/day a week)

[ ]  Sometimes (1 to 2 nights/days a week)

[ ]  Often (3 to 5 nights/days a week)

[ ]  Always (6 to 7 nights/days a week)

[ ]  Don’t Know

[ ]  No answer

Wakes up at night

[ ]  Never (does not happen)

[ ]  Not Often (<1 night/day a week)

[ ]  Sometimes (1 to 2 nights/days a week)

[ ]  Often (3 to 5 nights/days a week)

[ ]  Always (6 to 7 nights/days a week)

[ ]  Don’t Know

[ ]  No answer

Gets out of bed at night

[ ]  Never (does not happen)

[ ]  Not Often (<1 night/day a week)

[ ]  Sometimes (1 to 2 nights/days a week)

[ ]  Often (3 to 5 nights/days a week)

[ ]  Always (6 to 7 nights/days a week)

[ ]  Don’t Know

[ ]  No answer

Trouble staying in his/her bed at night

[ ]  Never (does not happen)

[ ]  Not Often (<1 night/day a week)

[ ]  Sometimes (1 to 2 nights/days a week)

[ ]  Often (3 to 5 nights/days a week)

[ ]  Always (6 to 7 nights/days a week)

[ ]  Don’t Know

[ ]  No answer

Grinds his/her teeth

[ ]  Never (does not happen)

[ ]  Not Often (<1 night/day a week)

[ ]  Sometimes (1 to 2 nights/days a week)

[ ]  Often (3 to 5 nights/days a week)

[ ]  Always (6 to 7 nights/days a week)

[ ]  Don’t Know

[ ]  No answer

Wets the bed

[ ]  Never (does not happen)

[ ]  Not Often (<1 night/day a week)

[ ]  Sometimes (1 to 2 nights/days a week)

[ ]  Often (3 to 5 nights/days a week)

[ ]  Always (6 to 7 nights/days a week)

[ ]  Don’t Know

[ ]  No answer

If snoring or noisy breathing is present, how noisy has your child usually been in the past month?

Does not apply

[ ]  Only slightly louder than heavy breathing

[ ]  About as loud as mumbling or talking

[ ]  Louder than talking

[ ]  Extremely loud – can be heard through a closed door

[ ]  Not sure

[ ]  No answer

1. **Morning Waking and Daytime Symptoms**

Noisy breathing

[ ]  Never (does not happen)

[ ]  Not Often (<1 night/day a week)

[ ]  Sometimes (1 to 2 nights/days a week)

[ ]  Often (3 to 5 nights/days a week)

[ ]  Always (6 to 7 nights/days a week)

[ ]  Don’t Know

[ ]  No answer

Morning headaches

[ ]  Never (does not happen)

[ ]  Not Often (<1 night/day a week)

[ ]  Sometimes (1 to 2 nights/days a week)

[ ]  Often (3 to 5 nights/days a week)

[ ]  Always (6 to 7 nights/days a week)

[ ]  Don’t Know

[ ]  No answer

Trouble getting out of bed in the morning

[ ]  Never (does not happen)

[ ]  Not Often (<1 night/day a week)

[ ]  Sometimes (1 to 2 nights/days a week)

[ ]  Often (3 to 5 nights/days a week)

[ ]  Always (6 to 7 nights/days a week)

[ ]  Don’t Know

[ ]  No answer

Takes a long time to become alert in the morning

[ ]  Never (does not happen)

[ ]  Not Often (<1 night/day a week)

[ ]  Sometimes (1 to 2 nights/days a week)

[ ]  Often (3 to 5 nights/days a week)

[ ]  Always (6 to 7 nights/days a week)

[ ]  Don’t Know

[ ]  No answer

Tardy for school or is missing school because of sleepiness

[ ]  Never (does not happen)

[ ]  Not Often (<1 night/day a week)

[ ]  Sometimes (1 to 2 nights/days a week)

[ ]  Often (3 to 5 nights/days a week)

[ ]  Always (6 to 7 nights/days a week)

[ ]  Don’t Know

[ ]  No answer

Acts sleepy or seems overtired a lot

[ ]  Never (does not happen)

[ ]  Not Often (<1 night/day a week)

[ ]  Sometimes (1 to 2 nights/days a week)

[ ]  Often (3 to 5 nights/days a week)

[ ]  Always (6 to 7 nights/days a week)

[ ]  Don’t Know

[ ]  No answer

Falls asleep in school

[ ]  Never (does not happen)

[ ]  Not Often (<1 night/day a week)

[ ]  Sometimes (1 to 2 nights/days a week)

[ ]  Often (3 to 5 nights/days a week)

[ ]  Always (6 to 7 nights/days a week)

[ ]  Don’t Know

[ ]  No answer

Naps after school

[ ]  Never (does not happen)

[ ]  Not Often (<1 night/day a week)

[ ]  Sometimes (1 to 2 nights/days a week)

[ ]  Often (3 to 5 nights/days a week)

[ ]  Always (6 to 7 nights/days a week)

[ ]  Don’t Know

[ ]  No answer

Gets weak in the knees or face with laughing or strong emotions

[ ]  Never (does not happen)

[ ]  Not Often (<1 night/day a week)

[ ]  Sometimes (1 to 2 nights/days a week)

[ ]  Often (3 to 5 nights/days a week)

[ ]  Always (6 to 7 nights/days a week)

[ ]  Don’t Know

[ ]  No answer

Feels like s/he can’t move arms or legs when waking up

[ ]  Never (does not happen)

[ ]  Not Often (<1 night/day a week)

[ ]  Sometimes (1 to 2 nights/days a week)

[ ]  Often (3 to 5 nights/days a week)

[ ]  Always (6 to 7 nights/days a week)

[ ]  Don’t Know

[ ]  No answer

Has nighttime like dreams during the date when awake

[ ]  Never (does not happen)

[ ]  Not Often (<1 night/day a week)

[ ]  Sometimes (1 to 2 nights/days a week)

[ ]  Often (3 to 5 nights/days a week)

[ ]  Always (6 to 7 nights/days a week)

[ ]  Don’t Know

[ ]  No answer

1. **Previous Airway Surgeries**

Did your child have his/her tonsils out?

[ ]  Yes

[ ]  No

If Yes, child’s age at time of surgery \_\_\_\_\_\_\_

Did your child ever have his/her adenoids out?

[ ] Yes

[ ]  No

If Yes, child’s age at time of surgery \_\_\_\_\_\_\_\_\_\_\_\_

1. **Family Sleep History**

Does anyone in your family have these sleep problems or are being treated by a physician for these problems

[ ]  Yes

[ ]  No

Put a check mark by all people with the problem:

Snoring

[ ]  Mother

[ ]  Father

[ ]  Brother/Sister

[ ]  Grandparent

Sleep apnea or uses a CPAP machine at night

[ ]  Mother

[ ]  Father

[ ]  Brother/Sister

[ ]  Grandparent

Narcolepsy

[ ]  Mother

[ ]  Father

[ ]  Brother/Sister

[ ]  Grandparent

Insomnia

[ ]  Mother

[ ]  Father

[ ]  Brother/Sister

[ ]  Grandparent

Sleep walking/sleep terrors

[ ]  Mother

[ ]  Father

[ ]  Brother/Sister

[ ]  Grandparent

Restless legs/periodic limb movements disorder

[ ]  Mother

[ ]  Father

[ ]  Brother/Sister

[ ]  Grandparent