

SUTTER SLEEP DISORDERS CENTER

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PEDIATRIC QUESTIONNAIRE
(Parent to fill out)

Patient Name: _____

Date of Birth: _____ Sex: ____ M ____ F

Ethnic Background: ____ Caucasian ____ Black ____ Asian
____ Spanish American ____ Other

Parent/Guardian Name: _____

Phone: Hm _____ Cell: _____

Referring Physician: _____ Phone: _____

Address: _____

Chief Complaint: _____

Duration of chief complaint: _____

Summary of problem: _____

- I. Does your child snore? YES NO
- A. Loudness: Soft Moderate Loud
- B. Regularity of Snoring: Night/week: 1 2 3 4 5 6 7
- Times/night few minutes few hours most of night all night
- C. How long has he/she been snoring? _____

PEDIATRIC QUESTIONNAIRE Continued

- II Have you noticed your child stop breathing during sleep? ___YES ___NO
- A. If so, does his/her chest continue to move? ___YES ___NO
- B. How often does this occur? _____
- C. Does your child have more of a tendency to stop breathing during upper respiratory infections (colds, etc)? ___YES ___NO

- III. Usual Bedtime _____ Usual time arise _____
- A. Average number of hours of sleep at night: _____
- B. Average number of hours of sleep during the day: _____
- C. Usual sleeping position: Stomach Back Side
- D. Does your child elevate his/her head during sleep? ___YES ___NO

IV. Regular Mediations: _____

V. Allergies: _____

VI. Please circle the answers according to the following codes:

N – never O – occasional F – frequent C – constant

- | | | |
|----|------------------------------------------|------|
| A. | Excessive daytime sleepiness: | NOFC |
| B. | Sweating when asleep | NOFC |
| C. | Restless sleep/arousals | NOFC |
| D. | Nighttime shortness of breath | NOFC |
| E. | nighttime choking/coughing: | NOFC |
| F. | Night muscle activity/leg kicking, etc.: | NOFC |
| G. | Morning headaches/nausea | NOFC |
| H. | Nightmares/hallucinations | NOFC |
| I. | Sleep walking | NOFC |
- VII. Leaning/Developmental Problems: (N/A – Non-applicable)
- | | | | | |
|----|---------------------------------|------------------------------|-----------------------------|------------------------------|
| A. | Delayed Development | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> N/A |
| B. | Speech Problems | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> N/A |
| C. | Poor School Performance | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> N/A |
| D. | Special School | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> N/A |
| E. | Poor appetite | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> N/A |
| F. | Frequent nausea/vomiting | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> N/A |
| G. | Difficulty swallowing | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> N/A |
| H. | Constant nose running | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> N/A |
| I. | Recurrent middle ear disease | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> N/A |
| J. | Hearing problem | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> N/A |
| K. | Mouth breathes when awake | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> N/A |
| L. | Frequent respiratory infections | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> N/A |
| M. | History of pneumonia | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> N/A |
- VIII. Any diagnosed respiratory problems?
- IX. Are there any problems with the child's face, neck, throat or nose structure?
- X. Has the child had any oral surgeries?

XI. Has the child had any neurological testing?

XII. Does your child have a heart problem?

XII. Other than sleep related breathing problems, does your child have any other medical problems or diagnoses? _____

What influences have motivated you to seek medical consultation, testing or treatment for your sleep/daytime tiredness concerns? (Check all that apply.)

- | | |
|------------------------------------------------------------|-------------------------------------------------|
| <input type="checkbox"/> AWAKE (Sleep Apnea Support Group) | <input type="checkbox"/> Primary care physician |
| <input type="checkbox"/> TV/Magazine infomercial | <input type="checkbox"/> Spouse/friend |
| <input type="checkbox"/> Radio Ad | <input type="checkbox"/> Employer |
| <input type="checkbox"/> Sutter literature/presentation | <input type="checkbox"/> Dentist |
| <input type="checkbox"/> Other | |