HealthCare

l University of Kentucky Hospital A.B. Chandler Medical Center
l UK HealthCare Good Samaritan Hospital
l UK HealthCare Ambulatory Services
l UK Dental and Oral Heatlh Clinics

SLEEP DISORDERS CENTER PEDIATRIC HISTORY

(Patient Label Here)

Child's Name:_____ Child's gender: q Male q Female

Child's Date of Birth:: _____ / _____ / _____ Child's Age: _____

Child's racial/ethnic background: q White/Caucasian q Black/African-American q Asian American

q Native American q Hispanic- Latino q Other: _____

Parent(s): _____

Patient's Primary Language: _____

Primary care physician: _____

Other physicians you would like us to contact: _____

Please describe any concerns regarding your child as it relates to this visit: _____

_____

What options have you already attempted to fix this problem? _____

_____

_____

_____

Sleep History:

Please answer the next two questions regarding the WEEKDAY sleep schedule:

What is the child's usual bed time? _____ What is the child's usual wake time? _____

Please answer the next two questions regarding the WEEKEND sleep schedule:

What is the child's usual bed time? _____ What is the child's usual wake time? _____

The next two questions pertain to the child's NAP schedule:

How many days of the week does the child take a nap? _____

If the child takes a nap, what is the duration? _____

Does the child have a regular night time bed routine? q Yes q No

Does the child have his/her own bedroom? q Yes q No

Does the child have his/her own bed? q Yes q No

Who puts the child to bed? _____

Is someone present when the child falls asleep? q Yes q No

Where does the child fall asleep? _____

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Where does the child sleep MOST of the night? _____

Where does the child wake up in the morning? _____

Does your child:

Resist going to bed? q Yes q No Do you think this is a problem? q Yes q No

Have difficulty falling asleep? q Yes q No Do you think this is a problem? q Yes q No

Awaken during the night? q Yes q No Do you think this is a problem? q Yes q No

Have difficulty falling back asleep? q Yes q No Do you think this is a problem? q Yes q No

Do you consider your child a poor sleeper? q Yes q No Do you think this is a problem? q Yes q No

Place an X in the appropriate column regarding your child's current sleep

	Never	Less than once per week	1-2 nights per week	3-5 nights per week	6-7 nights per week	Do not know
Has difficulty breathing during sleep						
Stops breathing during sleep						
Snores						
Has restless sleep						
Sweats during sleep						
Has nightmares						
Sleep walks						
Sleep talks						
Screams in sleep						
Kicks legs in sleep						
Wakes up at night						
Gets out of bed at night						
Resists going to bed						
Grinds teeth at night						
Describes an uncomfortable, creepy-crawly feeling in legs at night						
Wets bed						

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Place an X in the appropriate column regarding your child's daytime symptoms

	Never	Less than once per week	1-2 days per week	3-5 days per week	6-7 days per week	Do not know
Has trouble getting up in the morning						
Falls asleep at school						
Naps after school						
Is sleepy during the daytime						
Feels weak or loses control of muscles with strong emotions						
Reports inability to move when falling asleep or upon wakening						
Sees frightening images when falling asleep or upon wakening						

Medical History:

Pregnancy (circle one): Term Pre-term (weeks)_____ Complications of pregnancy? q YES q NO

Birth weight: _____ Birth length: _____ Post-natal complications: q YES q NO

Have there been any concerns expressed by your child's doctor about:

Growth: q YES q NO Motor skill development: q YES q NO

Language skill development: q YES q NO

Medical and Psychiatric conditions:

	YES	NO	Age at diagnosis	Current treatment
Frequent nasal congestion				
Trouble breathing through nose				
Sinus problems				
Chronic bronchitis or cough				
Allergies				
Asthma				
Frequent cold or flu				
Frequent ear infections				

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	YES	NO	Age at diagnosis	Current treatment
Frequent strep throat infections				
Difficulty swallowing				
Acid reflux (GERD)				
Poor or delayed growth				
Excessive weight				
Hearing Problems				
Speech Problems				
Vision problems				
Seizures/Epilepsy				
Morning headaches				
Cerebral palsy				
Heart Disease				
High Blood Pressure				
Diabetes				
Sickle Cell Disease				
Genetic Disease				
Chromosome problems				
Skeletal problems				
Craniofacial disorder				
Thyroid problems				
Eczema				
Pain				
Autism				
Developmental Delay				
Attention Deficit/Hyperactivity Disorder				
Anxiety/panic attacks				
Obsessive Compulsive Disorder				
Depression				
Suicide				
Learning Disability				
Drug use/abuse				
Behavioral Disorder				

Other: _____

Surgical History:

q Ear tubes q Tonsillectomy q Adenoidectomy q Cleft left lip or palate repair

Other surgeries: _____

_____

Allergies to medicines: _____

SLEEP DISORDERS CENTER PEDIATRIC HISTORY

(Patient Label Here)

Current medications:

_____

_____

_____

Family history:

Father's Age: _____ Living? q YES q NO

Marital status: q Single q Married q Divorced q Separated q Widowed q Remarried

Highest Level of Education: _____

Mother's Age: _____ Living? q YES q NO

Marital status: q Single q Married q Divorced q Separated q Widowed q Remarried

Highest level of Education: _____

Persons living in home:

Name	Age	Relationship

Please place an X in the appropriate column if there is a family history for any of the following conditions:

	Father	Mother	Brother/Sister	Grandparent
Snoring				
Sleep Apnea				
Heart Disease				
Hypertension				
Obesity				
Insomnia				
Sleep Walking				
Night terrors				
Restless leg syndrome				
Narcolepsy				

Social History:

City/county of residence, _____

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Conner's Abbreviated Symptom Questionnaire for children 3-17 years of age

	Observation	Not at all (0)	Just a little (1)	Pretty much (2)	Very much (3)
1	Restless or overactive				
2	Excitable, impulsive				
3	Fails to finish things he/she starts-short attention span				
4	Constantly fidgeting				
5	Disturbs other children				
6	Inattentive, easily distracted				
7	Demands must be met immediately-easily frustrated				
8	Cries often and easily				
9	Mood changes quickly and drastically				
10	Temper outbursts, explosive and unpredictable behavior				

Total _____

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Modified Epworth Sleepiness Scale for children

How likely is your child to doze off or fall asleep in the following situations, in contrast to feeling just tired? This refers to your usual way of life in recent time. Even if your child has not done some of these things recently, try to recall how they would have affected your child. Use the following scale to choose the most appropriate number for each situation:

0- No chance of dozing
1- Slight chance of dozing
2- Moderate chance of dozing
3- High chance of dozing

	Situation	Chance of Dozing
1	Sitting and Reading	
2	Sitting and watching TV or a video	
3	Sitting in a classroom during the morning	
4	Sitting/riding in a car or bus for 30 min	
5	Lying down to rest or nap in afternoon	
6	Sitting and talking to someone	
7	Sitting quietly by him/herself after lunch	
8	Sitting and eating a meal	

Total _____

_____ _____
Patient Signature Date

_____
Signature of Legal Representative and Relationship to Patient Date _____

_____ _____
Provider Signature Date / Time

_____
Interpreter Name or ID# In person or via Cyracom (circle one)

SLEEP DISORDERS CENTER PEDIATRIC HISTORY

INSTRUCTIONS:

1. Write the date, day of the week, and type of day: Work, School, Day Off, or Vacation.
2. Put the letter "C" in the box when you have coffee, cola or tea. Put "M" when you take any medicine. Put "A" when you drink alcohol. Put "E" when you exercise.
3. Put a line (|) to show when you go to bed. Shade in the box that shows when you think you fell asleep.
4. Shade in all the boxes that show when you are asleep at night or when you take a nap during the day.
5. Leave boxes unshaded to show when you wake up at night and when you are awake during the day.

SAMPLE ENTRY BELOW: On a Monday when I worked, I jogged on my lunch break at 1 PM, had a gladd of wine with dinner at 6 PM, fell asleep watching TV from 7 to 8 PM, went to bed at 10:30 PM, fell asleep around Midnight, woke up and couldn't get back to sleep at about 4 AM, went back to sleep from 5 to 7 AM, and had coffee and medicine at 7:00 in the morning.

Today's Date	Day of the Week	Type of Day- Work, School, Off, Vacation	Noon	1 PM	2	3	4	5	6 PM	7	8	9	10	11 PM	Midnight	1 AM	2	3	4	5	6 AM	7	8	9	10	11AM	
sample	Mon.	Work		E					A				|								C M					
									A																		Week 1
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