POMONA VALLEY HOSPITAL
MEDICAL CENTER

SLEEP DISORDERS CENTER

Pediatric Sleep Questionnaire
6 – 13 years

Name:_____
First Middle Last

Sex: Male Female Date of Birth:_____

Height_____ Weight_____

Mother's Name:_____ Father's Name:_____

Please circle or fill in the answer.

1. Describe what the sleep problem is:_____
2. How long has this been a problem:_____
3. How serious do you believe this problem is?
   VERY SERIOUS
   SOMEWHAT SERIOUS
   NOT AT ALL SERIOUS
4. What type of bedding do you sleep on? MATTRESS WATERBED CHAIR
5. Do others sleep in the same room?_____
6. Do others sleep in the same bed?_____
7. Do you sleep better out of your bed (for example on the couch or in a hotel room)? YES
   NO _____
8. How do you feel when you get up?
   ALERT & RESTED SLUGGISH VERY GROGGY
9. How long does it take you to "GET GOING" in the morning?
   FEW MINUTES 30 MINUTES AN HOUR OR MORE
10. Grade Average: A B C D F

Does the child have any complaints on waking? YES NO

If yes, please describe:_____

_____

POMONA VALLEY HOSPITAL
MEDICAL CENTER

SLEEP DISORDERS CENTER

	SCHOOL NIGHTS	WEEKENDS
What time do you normally get into bed?		
How long does it normally take you to get to sleep?		
What wakes you up?		
How long does it take to return to sleep after awakening?		
What time is your regular morning wake up time?		
Do you wake up spontaneously or by an alarm clock?		
When do you get out of bed?		
What time does school start?		
Hours of Sleep you normally get		
Hours of Sleep you need to feel rested		

11. What is your best time of day (when most alert)?_____

12. What is your worst time of day (when most sleepy)?_____

13. How frequently do you take naps? _____

14. Describe time of day and length of nap?_____

15. How do you feel after taking a nap?

    VERY REFRESHED SOMEWHAT REFRESHED

    SOMEWHAT TIRED VERY DROWSY

16. Have you ever had an over-powering, irresistible attack of sleep?

    YES NO If yes, describe how frequently this occurs and in what situations._____

    _____

17. Do you ever lose muscle strength when excited, startled, angry, or laughing?

    YES NO (for example weakness in knees, sagging facial muscles or total collapse)

18. Do you ever feel paralyzed (can't move) as you go to sleep or as you wake up?

    YES NO

POMONA VALLEY HOSPITAL
MEDICAL CENTER

SLEEP DISORDERS CENTER

19. Do you ever see or hear things that you don't think are real as you go to sleep or as you wake up.
YES NO

20. Do any family members have symptoms listed in the last three questions? YES NO

21. Do you experience unpleasant sensations in your legs? YES NO
if yes, describe them and what you do to relieve them:_____

_____

22. Have you been told you kick in your sleep? YES NO if yes, does this wake you up? YES NO

23. Do you snore? YES NO

24. Does your snoring bother others? YES NO

25. Have you been told you stop breathing during sleep? YES NO

26. Are you an active sleeper (awaken to find the sheet in disarray)? YES NO

27. Do you sweat excessively at night? YES NO

28. Do you wake up gasping, choking or feeling short of breath? YES NO

Indicate the amount (and times) of the following beverages:

	Daily	**After 6 PM**	**At Bedtime**	**Weekly**
Regular Coffee (cups)				
Decaf Coffee (cups)				
Carbonated drinks (soda cans, bottles)				
Tea (glasses)				

POMONA VALLEY HOSPITAL
MEDICAL CENTER

SLEEP DISORDERS CENTER

How likely are you to doze off or fall asleep in the following situations, not just feeling tired? Use the following scale to choose the most appropriate number for each situation.

0 = would never fall asleep
1 = slight chance of falling asleep
2 = moderate chance of falling asleep
3 = high chance of falling asleep

SITUATION	**Chance of falling asleep**
Sitting and reading	
Watching TV	
Sitting in class listening to the teacher	
Doing homework	
As a passenger in a car for an hour	
After meals	
During a movie at the theater	
In a car, while stopped for a few minutes in traffic	
TOTAL	

HAVE YOU EVER EXPERIENCED ANY OF THE FOLLOWING DURING SLEEP?

	Times per week	**Age began**	**Last occurrence**	**Treatment (if any)**
Talking during sleep				
Sleepwalking				
Grinding teeth during sleep				
Bedwetting				
Recurrent dreams				
Disturbing dreams				
Waking with acid or sour taste				
Waking screaming & fearful in the first 3 hours of night				
Chest pain, wheezing, rapid or irregular heart beat during sleep				
Unusual movements during sleep				
Awakening with headache or excessive perspiration				

How much sleep do you think you need? _____

POMONA VALLEY HOSPITAL
MEDICAL CENTER

SLEEP DISORDERS CENTER

Medications:

Name:	Dose:	Time of Day