Children's Hospital
Greenville Health System

Center for Pediatric Sleep Disorders
New Patient Questionnaire

Date: _____

Child's Name: _____ **DOB**: _____

Ethnicity:

☐ Caucasian ☐ American Indian ☐ Alaskan Native ☐ African American
☐ Asian ☐ Hispanic ☐ Polynesian ☐ Other

Why is your child being seen today? _____
_____

Medical History:

Was your child premature?	☐ No	☐ Yes	How many weeks?	_____
Was your child intubated after birth?	☐ No	☐ Yes	How long?	_____
Did your child require oxygen after birth?	☐ No	☐ Yes	How long?	_____
Has your child ever been hospitalized?	☐ No	☐ Yes	Specify:	_____

Does your child currently have or have they ever had:

☐ Poor weight gain	☐ Obesity	☐ ADHD	☐ Seizure disorder
☐ Asthma	☐ Chronic lung disease	☐ Anxiety	☐ Gastroesophageal reflux (heartburn)
☐ Nasal polyps	☐ Allergies/ Hay fever	☐ Depression	☐ Heart disease

☐ Airway abnormality (tracheomalacia, laryngomalacia, vocal cord dysfunction or paralysis), specify:
_____
_____

☐ Genetic syndrome, specify:
_____
_____

☐ Other medical problems/diagnoses, specify:
_____
_____

☐ Other neurobehavioral or mental health conditions, specify:
_____
_____

☐ Do you have any concerns that your child has symptoms of behavioral problems/ADHD?
_____
_____

☐ Do you have any concerns that your child has symptoms of gastroesophageal reflux?
_____
_____

Surgery History Has your child ever had surgery on his or her:

☐	Tonsils	☐ No	☐ Yes, when:	_____
☐	Adenoids	☐ No	☐ Yes, when:	_____
☐	Ears	☐ No	☐ Yes, when:	_____
☐	Nose	☐ No	☐ Yes, when:	_____
☐	Vocal Cords	☐ No	☐ Yes, when:	_____
☐	Airway	☐ No	☐ Yes, when:	_____
☐	Sinuses	☐ No	☐ Yes, when:	_____
☐	Jaw	☐ No	☐ Yes, when:	_____
☐	Teeth	☐ No	☐ Yes, when:	_____
☐	Palate	☐ No	☐ Yes, when:	_____
☐	Nissen Fundoplication	☐ No	☐ Yes, when:	_____

Please list any other surgeries not listed above and specify when they occurred: _____
_____
_____
_____

Medication History:

Does your child take any daily medications?	☐ No	☐ Yes
Does your child take any medications on an as-needed basis?	☐ No	☐ Yes
Does your child take any over-the-counter medications, herbals, or vitamins?	☐ No	☐ Yes
Does your child take any medications for mental health reasons?	☐ No	☐ Yes

If you answered **yes** to any of the above questions, please list all the medications below:

Medication	Dose	Frequency	Date Started

Does your child have an **allergy** to any medications? ☐ No ☐ Yes, specify: _____
_____ _____ _____
_____ _____ _____

Labs and Diagnostic Testing:

Have you ever had:

Any previous evaluation for your child's sleep disturbance? ☐ No ☐ Yes, from whom? _____

A measurement of your child's nighttime oxygen levels? ☐ No ☐ Yes: ☐ Normal ☐ Abnormal

A polysomnogram or sleep study performed on your child? ☐ No ☐ Yes: ☐ Normal ☐ Abnormal

Diagnosis from polysomnography: _____

Has your child ever had any of the following test/procedures?

Labs	☐ No	☐ Yes, where?	_____
EKG	☐ No	☐ Yes, where?	_____
Echocardiogram	☐ No	☐ Yes, where?	_____
EEG	☐ No	☐ Yes, where?	_____
pH Probe	☐ No	☐ Yes, where?	_____
Upper GI	☐ No	☐ Yes, where?	_____
Swallow Studies	☐ No	☐ Yes, where?	_____
X-rays _____	☐ No	☐ Yes, where?	_____
MRI _____	☐ No	☐ Yes, where?	_____
CT Scan _____	☐ No	☐ Yes, where?	_____

Review of Systems:

(Please indicate if your child is having any of these complaints right now)

__ Fever or chills
__ Sweat excessively
__ Vision problems
__ Hearing problems
__ Speech difficulties
__ Swallowing problems
__ Nighttime cough
__ Daytime cough
__ Wheezing
__ Breathing/lung problems
__ Chest pains
__ Heart palpitations
__ Stomach or intestinal problems
__ Diarrhea
__ Constipation
__ Liver problems
__ Problems urinating
__ Numbness
__ Fainting spells
__ Fatigue, loss of energy
__ Weight gain
__ Weight loss
__ Swollen glands
__ Hormonal problems (thyroid or other)
__ Blood diseases
__ Low iron levels
__ Low red blood cells/Anemia
__ Muscle problems
__ Muscle pain
__ Bone pain
__ Drug or alcohol use
__ Developmental problems
__ Stress
__ School problems
__ Mood problems
__ Behavioral problems

Family History:

Are there any family members with the following problems? (If so, please specify who and if on mother's side, father's side.):

Obstructive Sleep Apnea	_____	Reflux/Heartburn	_____
Restless Legs Syndrome	_____	Allergies/Hay fever	_____
Periodic Limb Movement Disorder	_____	Asthma	_____
Sleepwalking	_____	Obesity	_____
Night terrors	_____	Eczema	_____
Insomnia	_____	Anemia/Low Iron Levels	_____
Narcolepsy	_____	Depression	_____
History of Bed Wetting	_____	Chronic Fatigue	_____
Seizures	_____	Fibromyalgia	_____
Heart Disease	_____	Anxiety/Panic Disorder	_____

Other, specify: _____

Does anyone in the family snore? If yes, please specify who: _____

Does anyone in the family (including the patient) use nighttime:

☐ CPAP If so who? _____ ☐ Oxygen If so who? _____ ☐ BiPAP If so who? _____

Social History:

Parent(s): ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Single

Who lives at home with your child? (Check all that apply)

☐ Father ☐ Mother ☐ Foster Care ☐ Relatives, specify: _____ ☐ Other _____ # of siblings _____

☐ Was your child adopted? ☐ No ☐ Yes If yes, how old were they? _____

Do you own any pets? If yes, please specify: _____

Is your child around anyone who smokes (either inside or outside of the home)?	☐ No	☐ Yes		
Does your child smoke?	☐ No	☐ Yes		
Does your child drink caffeinated beverages?	☐ No	☐ Yes. How many per day?		_____
Does your child participate in any extra-curricular activities?	☐ No	☐ Yes, specify		_____
Does your child exercise/play vigorously daily?	☐ No	☐ Yes, specify		_____
Are you aware of any stressors in your child's life (bullying, abuse, etc.)?	☐ No	☐ Yes, specify		_____
Has your child needed any counseling for behavioral or mood problems?	☐ No	☐ Yes, specify		_____

How many hours per day does your child spend watching TV or playing video games or on the computer? _____

If school age, in what grade is your child? _____

Correct grade for age? ☐ Yes ☐ No If no, why? ☐ Held back a grade ☐ Moved up a grade

Performance in school: ☐ Above Average ☐ Average ☐ Below Average ☐ Special education service

Is your child in daycare? ☐ Yes ☐ No

Sleep History:

What time does your child:

go to bed on weeknights? _____ wake up for the day on weekdays? _____

go to bed on weekend nights? _____ wake up for the day on weekends? _____

Once in bed, how long (on average) does it take for your child to fall asleep? _____

Do you think your child gets enough sleep? □ No □ Yes

Are you concerned that your child is tired? □ No □ Yes

How much variation in bedtime/awakening time occurs from night to night? □ None □ Rarely □ Occasionally □ A lot

Does your child have a TV, radio, I-pod, cell phone or other electronic device at night? □ No □ Yes. If yes, is it turned on? □ No □ Yes

Does your child require any special routine or object to aid him/her in going to sleep, such as pacifier, stuffed animal, special music, rocking, patting, etc.?
□ No □ Yes, please explain: _____

Describe your child's bedtime routine: _____

Does your child wake during the night? □ No □ Yes If yes, when? _____
# of awakenings per night_____ How long is your child awake_____

Does your child take naps? □ No □ Yes: Naps per day? _____ How long? _____

Does your child snore while sleeping? □ No □ Yes
If yes: □ barely audible □ heard inside your child's room □ heard outside your child's room □ disturbs the household

At what age did you first notice your child snoring? _____

Would you describe your child's snoring as (check all that apply):
□ continuous □ intermittent □ associated with gasping or choking □ interrupted by long pauses of no breathing

How does your child like to sleep? □ flat □ supported by pillows □ sitting up in chair

Has your child ever appeared dusky or blue at night?	□ No	□ Yes	
If your child doesn't typically snore, will he/she snore with cold symptoms?	□ No	□ Yes	
Does your child assume unusual sleeping positions?	□ No	□ Yes,	specify:_____
Have you ever noticed that your child works hard to breathe at night?	□ No	□ Yes,	specify:_____
Does your child: breathe through his/her mouth during the day?	□ No	□ Yes	
: breathe through his/her mouth during the night, while sleeping?	□ No	□ Yes	
Does your child have bad breath?	□ No	□ Yes	

Does your child drool? □ No □ Yes □ Awake □ Sleep

Does your child: (Check all that apply.)

- ☐ Sleep talk
- ☐ Sleep walk
- ☐ Grind teeth
- ☐ Wet the bed
- ☐ Have night terrors
- ☐ Act fearful/terrified at bedtime
- ☐ Act fearful/terrified/anxious during the daytime
- ☐ Have difficulty falling asleep (takes more than 20-30 minutes for child to fall asleep once in bed)
- ☐ Have nightmares
- ☐ Have an inability to move his/her body (paralysis) upon falling asleep or upon awakening
- ☐ Have hallucinations upon falling asleep or upon awakening
- ☐ Become weak, especially when excited, angry, or laughing
- ☐ Complains of being sleepy or tired
- ☐ Ever have sleep attacks, or suddenly and unexpectedly fall asleep
- ☐ Fall asleep at school
- ☐ Fall asleep in odd situations or places
- ☐ Have difficulties with attention, sitting still, or staying focused
- ☐ Have behavioral problems
- ☐ Have twitching in legs awake and asleep
- ☐ Have pain in legs
- ☐ Have headaches
- ☐ Sweat excessively

Parent's Name(s) _____

This questionnaire was filled out by: _____Relationship to patient:_____

Address: _____ City/Zip Code: _____

Day Phone: _____ Evening Phone: _____

Cell Phone: _____ Email address: _____

What telephone number would you like for the clinic to use to get in contact with you?

_____

At which of the numbers above would we be allowed to leave private health information, including test results, if we cannot reach you in person?

☐ Day Phone ☐ Evening Phone ☐ Cell Phone

Other than the person filling out this form, with whom else can health information about your child be left?

List names:

_____ Relationship to patient: _____
_____ Relationship to patient: _____
_____ Relationship to patient: _____
_____ Relationship to patient: _____
_____ Relationship to patient: _____

Children's Hospital
Greenville Health System

Center for Pediatric Sleep Disorders **Today's Date:_____**

Please list all the physicians and medical contacts that you would like for this practice to send a copy of today's evaluation to:

Name of Practice (Primary Care Physician in first row)	Specialty	First Name	Last Name	Address (if known)	Phone Number (if known)	Fax Number (if known)
					( )	( )
					( )	( )
					( )	( )
					( )	( )
					( )	( )

Patient's Name: _____ DOB:_____
Print Parent or Guarantor Name: _____
Parent or Guarantor's Signature: _____