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Sleep Disorder Center of SANTA MARIA

ACCREDITED MEMBER CENTER

A Full Service Sleep Disorder Center
Accredited by The American Academy of Sleep Medicine

Pediatric Sleep Questionnaire *

Indicate by circling Yes/No if your child has any of the following:

Snoring – soft (evident standing near child only)	Yes	No
Snoring – moderate (evident outside child's room)	Yes	No
Snoring – loud (evident from another room)	Yes	No
Daytime sleepiness, fatigue or low energy	Yes	No
Waking, gasping for air	Yes	No
Observed struggling to breathe during sleep	Yes	No
Observed pauses of breathing during sleep	Yes	No
Cyanosis (blue/gray coloring around lips, eyes, and finger tips during sleep)	Yes	No
Excessive sweating during sleep	Yes	No
Sleeping in an upright position	Yes	No
Enuresis (bed wetting)	Yes	No
Morning headache	Yes	No
Insomnia/ difficulty initiating or maintaining sleep	Yes	No
Frequent waking	Yes	No
Nightmares	Yes	No
Hypertension	Yes	No
Sleep walking	Yes	No
Sleep talking	Yes	No
Excessive movement during sleep- kicking, thrashing or jerking	Yes	No
Poor scholastic performance, learning disabilities or inattentiveness	Yes	No
ADD / ADHD / Hyperactivity	Yes	No
Other behavioral problems/ inappropriate behavior	Yes	No

* Based on recommendations made by American Academy of Pediatrics, Practice Guideline Update
Diagnosis and Management of Childhood Obstructive Sleep Apnea Syndrome
http://pediatrics.aappublications.org/content/early/2012/08/22/peds.2012-1671

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1. What time does your child usually go to bed? _____

2. What is your child usual bedtime routine? _____

3. How do you help your child sleep? _____

4. What electronic devices are available in your child's room (computer TV tablets phone, etc.)

5. Does your child share a room or bed with anyone? **Yes / No**

If yes please describe: _____

6. What snacks if any does your child eat or drink prior to bed?

7. Is there any other information pertaining to your child's sleep you wish to share?

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