MADISON MEMORIAL HOSPITAL

Pediatric Follow-up Comprehensive Intake—Sleep Clinic

Name: _____ **Date of Birth:** _____ **Date**:_____

Section 1: ID Risk Screen

☐ No Travel History ☐ Last 7 Days ☐ Last 14 Days ☐ Last 21 Days ☐ Last 2 Months

Recent Travel Location: _____

Family Member/Household/Contact Travel History

☐ No Travel History ☐ Last 7 Days ☐ Last 14 Days ☐ Last 21 Days ☐ Last 2 Months

Recent Travel Location: _____

*Contact with person with highly contagious disease (Ebola/MERS/2019-nCoV) AND have one or more of the systems below: ☐ Yes ☐ No

*Travel to a country with wide-spread (Ebola/MERS/2019-nCoV) in the past 21 days AND have one or more of the systems below: ☐ Yes ☐ No

Ebola Symptoms: Fever, Headache, Weakness, Muscle Pain, Vomiting, diarrhea, Abdominal Pain or Hemorrhage

MERS (Middle East Respiratory Syndrome) Symptoms: Fever, Chills/Rigors, Headache, Sore Throat, Cough, Difficulty Breathing, Nausea, Vomiting, Diarrhea, Abdominal Pain or Muscle Pain
Zika Symptoms: Macular or Papular Rash, Fever, Arthralgia or Conjunctivitis
Some symptoms are not unique for TB. For new or worsening cough, provide patient with a mask.
2019-nCov (2019-nCoV Novel Coronavirus) Symptoms: Fever and symptoms of lower respiratory illness (e.g., cough, difficulty breathing)
Infectious Disease Risk Factors/Symptoms—*(Only if YOU or FAMILY MEMBER has traveled)*

	Yes	No
Chills		
Fever		
Fatigue		
Headache		
Runny or Stuffy Nose		
Sore Throat		
Difficulty Breathing		
Shortness of Breath		
New or Worsening Cough		
Wheezing		

	Yes	No
Vomiting		
Diarrhea		
Abdominal(Stomach Pain)		
Weakness/Numbness		
Exposure to Disease		
Abnormal Breathing		
Unexplained bruising		
Joint Pain		
Abscess		
Rash		

MDRO History Surveillance

	Yes	No
History of Clostridium Difficile		
History of Extended Spectrum beta-Lactamase		
History of MRSA		
History of Vancomycin-resistant enterococci		
History of Carbapenem-resistant Enterobacteriaceae		
Other		

Verify droplet, Contact Isolation for Ebola : ☐ Yes ☐ N/A

*Verify Airborne, Contact Isolation for MERS/2019-CoV: ☐ Yes ☐ N/A

Does the Patient Have any of the Following Conditions That Compromise the Immune System

○ None ○ Acquired immune deficiency syndrome (AIDS) ○ AIDS related complex (ARC) ○ Any immunodeficiency syndrome ○ Chronic Lymphocytic Leukemia (CLL) ○ Congenital or hereditary immunodeficiency ○ Human Immunodeficiency Virus (HIV) ○ Leukemia within 90 days ○ Lymphocytic Leukemia within 90 days ○ Marked Neutropenia within 90 days ○ Myelodysplasia within 90 days	○ Myelogenic Leukemia within 90 days ○ Organ Transplant ○ Pancytopenia within 90 days ○ Prior hospitalization within 14 days ○ Radiation therapy within 90 days ○ Significant neutropenia within 90 days ○ Systemic chemotherapy within 90 days ○ Systemic corticosteroid/Prednisone therapy within 90 days ○ Systemic immunosuppressive therapy within 90 days

Section 2: Summary

Chief Complaint: _____

Neck Circumference: _____inches

Onset of Symptoms: _____

Additional Information: _____

Preferred Language: _____ Method of Arrival: _____

Arrived With: _____ Consent Signed: _____

Onset of Symptoms: _____ Last Menstrual Period: _____

Vitals:

BP: _____ BP site: _____ HR: _____ HR Site: _____

Temp: _____ Site: _____ RR: _____ SpO2 %: _____ O2: _____

Measurements:

Height: _____in/cm Weight: _____lb/kg Method Weight Obtained: _____

Head Circumference: _____ cm Chest Circumference: _____ cm

Abdominal Circumference: _____ cm

Section 3: Problems and Visit Diagnosis: Any changes from your previous visit?

Diagnosis: Why are you being seen today?

_____

Past Medical History:

Date	Problem

Section 4: Medications/Allergies: Any changes from your previous visit?

Please list **medications** (including supplements) you are taking now, as well as the **dose** and **date** you started taking it (if known):

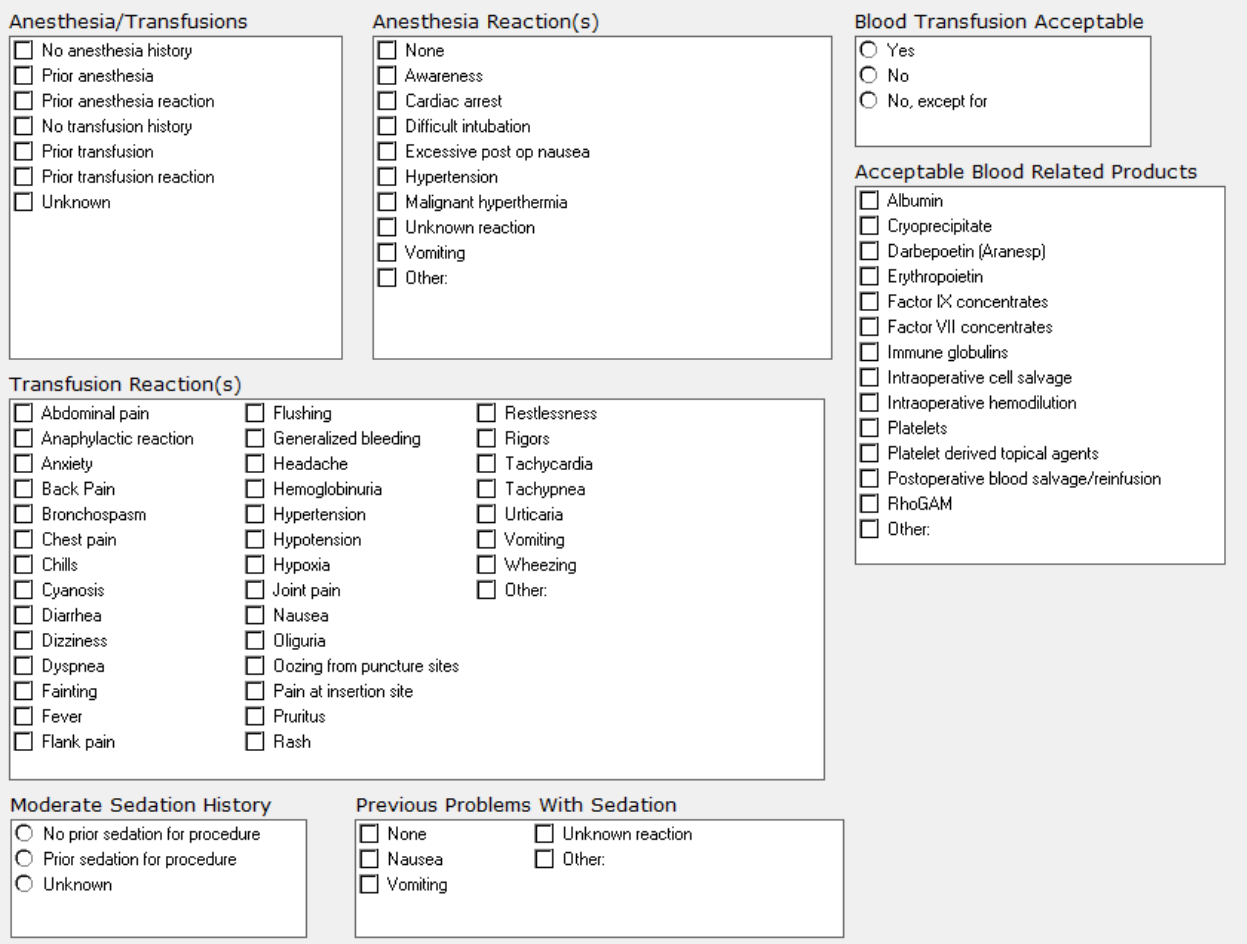
Medication Name	Dose (amount taking)	Start Date

Please list any known **allergies** you have, as well as the **type of reaction**:

Allergy	Type of Reaction
Do You have a Latex (rubber) allergy?	☐ Yes ☐ No

Section 5: Procedures/Surgeries: Any changes from your previous visit?

Anesthesia and Transfusions:



Section 6: Family History: Any changes from your previous visit?

Section 7: History

Have you been hospitalized outside the US in past 6 months? ☐ Yes ☐ No

Patient shows signs/symptoms of neglect? ☐ Yes ☐ No

History Assessed: ☐ Yes ☐ No

Have you used Tobacco anytime during the past 30 days? ☐ Yes ☐ No

Alcohol Use: ☐ Current ☐ Past ☐ Never

Type: ☐ Beer ☐ Wine ☐ Liquor ☐ Other:

Frequency: ☐ 1-2 x year ☐ 1-2 x month ☐ 1-2 x week ☐ 3-5 x week ☐ Daily ☐ Several x Day

Tobacco Use:

☐ Current Status unknown ☐ Unknown if ever smoked ☐ Current every day smoker

☐ Current some day smoker ☐ Former smoker ☐ Never smoker

☐ Heavy tobacco smoker ☐ Light tobacco smoker

Electronic Cigarette Use:

☐ Never ☐ Use, within 90 days ☐ Former use, greater than 90 days

☐ Refused screening ☐ Unknown/Not Obtained ☐ Other

Type: _____ Uses/Inhales per day: _____

Substance Use: ☐ Current ☐ Past ☐ Never

Type: _____

Section 8: Morse Fall Risk

History of Falling Immediate or Within Last 3 Months: ☐ Yes ☐ No

Presence of Secondary Diagnosis: ☐ Yes ☐ No

Use of Ambulatory Aid: ☐ Furniture ☐ Crutches, cane, walker ☐ None, bedrest, wheelchair

IV/Heparin Lock: ☐ Yes ☐ No

Gait/Transferring: ☐ Impaired ☐ Weak ☐ Normal, bedrest, immobile

Mental Status: ☐ Forgets Limitations ☐ Oriented to own ability

Section 9: Advance Directives

Advance Directives: ☐ Yes ☐ No

Patient Wishes to Receive Further Information on Advance Directives: ☐ Yes ☐ No

Section 10: Health Status

Allergies Verified	Meds Verified	History Verified
○ Yes ○ No	○ Yes ○ No	○ Yes ○ No

Immunizations Current: ☐ Yes ☐ No ☐ Non Received ☐ Unknown ☐ Vaccine Recommended

☐ Other

Patient Counseled

- ☐ Nutrition
- ☐ Other:
- ☐ Physical activity
- ☐ Elevated BMI

Medical Devices

- ☐ None
- ☐ Pacemaker
- ☐ Implantable cardioverter-defibrillator
- ☐ Other:
- ☐ Insulin pump
- ☐ Medication pump

Durable Medical Equipment

- ☐ Oxygen therapy
- ☐ Commode
- ☐ Immobilizer
- ☐ Walker
- ☐ CPAP
- ☐ Other:
- ☐ Wheelchair
- ☐ Spirometry
- ☐ Bed
- ☐ Splint

Section 11: Adult Depression Screening

Complete if 12 years old or younger

PHQ2-PHQ9 Screening:

Over the past 2 weeks, how often have you been bothered by any of the following problems?	Not At All	Several Days	More than ½ the Days	Nearly Every Day
1. Little interest or pleasure in doing things:	0	1	2	3
2. Feeling down, depressed or hopeless:	0	1	2	3
If you answered 0 to the questions above- stop				
3. Trouble falling asleep, staying asleep or sleeping too much:	0	1	2	3
4. Feeling tired or having little energy:	0	1	2	3
5. Poor appetite or overeating:	0	1	2	3
6. Feeling bad about yourself:	0	1	2	3
7. Trouble concentrating:	0	1	2	3
8. Moving or speaking so slowly:	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way:	0	1	2	3
10. Difficulty at work, home, or getting along with others:	0	1	2	3
Column Totals:				
Add Totals Together:				

11. If you checked off any problems, how difficult have those problems made it for you to do your work, take care of things at home, or get along with other people?

☐ Not Difficult at all ☐ Somewhat Difficult

☐ Very Difficult ☐ Extremely Difficult

Pediatric Questionnaire - Sleep Clinic

Please completely fill in the circles which best describe your current condition. Please answer all questions. Thank you

Pulmonary:	Yes	No
Shortness of breath at rest	O	O
Shortness of breath with exercise	O	O
Frequent cough	O	O
Coughing up blood	O	O
Chest pain	O	O
Wake up at night short of breath	O	O
Recurrent chest infections	O	O
Exposure to tuberculosis	O	O
Wheezing	O	O
Blood clot in legs or lungs	O	O
Cardiac:		
High blood pressure	O	O
Heart attack	O	O
Leg swelling	O	O
Heart racing or thumping	O	O
Rheumatic fever	O	O
Needs to sleep on 2 or more pillows	O	O
High cholesterol	O	O
Constitutional symptoms:		
Fever	O	O
Night sweats	O	O
Chills	O	O
Weight loss	O	O
Musculoskeletal:		
Muscle weakness	O	O
Joint pain	O	O
Joint swelling	O	O
Psychiatric:		
Depression	O	O
Anxiety	O	O
Poor sleep	O	O
Snoring	O	O
Morning headaches or awakening	O	O
Excessive sleep during day	O	O
Panic attacks	O	O

Gastrointestinal:	Yes	No
Trouble swallowing	O	O
Choking on food	O	O
Heartburn	O	O
Abdominal pain	O	O
Nausea	O	O
Vomiting	O	O
Diarrhea	O	O
Ulcers	O	O
Jaundice	O	O
Renal:		
Blood in urine	O	O
Urinary tract infections	O	O
Kidney stones	O	O
Frequent urination at night	O	O
Painful urination	O	O
Neurologic:		
Stroke	O	O
Migraines	O	O
Frequent headaches	O	O
Numbness or tingling	O	O
Seizure	O	O
Dizziness	O	O
Imbalance or unsteadiness	O	O
Vertigo	O	O
Hematology/Oncologic:		
Anemia	O	O
Cancer	O	O
Bleeding tendency	O	O
Blood transfusion	O	O
ENT:		
Blurred vision	O	O
Decreased hearing	O	O
Frequent sore throat	O	O
Sinus infections	O	O
Hay fever	O	O
Hoarseness	O	O

1. Child's usual bedtime on weeknights: _____am/pm
2. Child's usual wake time on weekdays: _____am/pm
3. Child's usual bedtime on weekends: _____am/pm
4. Child's usual wake time on weekends: _____am/pm
5. On average, how many hours does your child sleep per night? _____hours
6. How long does it usually take your child to fall asleep? _____minutes
7. Under usual circumstances, how often does your child awaken during the night: _____times per night
8. Does your child return to sleep without assistance after waking at night? yes/no
9. Does your child awaken too early and have difficulty going back to sleep? yes/no
   If "yes" estimate how many times per week: _____times per week
10. Does your child fall asleep alone in his/her own bed? yes/no
11. Does your child need someone in the room to fall asleep? yes/no
12. Does your child need a special object to fall asleep? yes/no
13. Does your child go to bed without a struggle? yes/no
14. Is your child afraid to sleep in the dark? yes/no
15. How long has your child experienced sleep problems? _____months
16. Does your child snore? yes/no
    If "yes" estimate how long: _____months
17. Does your child grind his/her teeth during sleep? yes/no
    If "yes" estimate how long: _____months
18. Does your child get up in the night to use the restroom? yes/no
19. Does your child stop breathing during sleep? yes/no
20. Does your child complain of awakening with a sensation of choking during the night? yes/no
21. Does your child breath with his/her mouth open while sleeping? yes/no
22. Does your child's arms and legs jerk during sleep? yes/no
23. Does your child sleep walk? yes/no
24. Does your child talk during sleep? yes/no

25. Does your child complain of body pain during sleep? yes/no
    If "yes" what type? _____type
26. Does your child usually seem rested when he/she wakes up? yes/no
27. Does your child usually wake up by him/herself? yes/no
28. Does your child have difficulty getting up in the morning? yes/no
29. How long does it usually take for your child to become alert in the morning? _____minutes
30. Does your child feel sleepy during the day? yes/no
31. How long has daytime sleepiness been a problem for your child? _____months
32. Does your child usually take naps during the day? yes/no
33. Does your child usually seem tired? yes/no
34. Does sleepiness interfere with your child's normal work/school performance? (Include his/her job and/or home activities) yes/no
35. Does sleepiness interfere with your child's normal social activities with family, friends, or other groups? yes/no
36. Has your child had accidents or near accidents because of sleepiness? yes/no
37. Have you ever been told that a family member has a sleep disorder? yes/no
    Type of sleep disorder:_____
38. When your child is angry, laughing, or frightened, does he/she complain of feeling weak as though he/she might fall? yes/no
39. Does your child remember dreams? yes/no
40. Does your child have nightmares? yes/no
    If "yes" estimate how many per week: _____per week
41. Does your child ever wake up screaming/yelling from a nightmare? yes/no
    If "yes" estimate how many times per week: _____per week
42. When your child falls asleep or just before he/she wakes up does he/she:
    a. Have bizarre dreams? yes/no
    b. Feel as if he/she is paralyzed? yes/no
43. Does your child have difficulty concentrating? yes/no
44. Has your child recently had problems with memory/attention to detail? yes/no
45. Have you noticed a difference in your child's personality in the last six months? yes/no

46. Does your child feel stressed? yes/no
47. Does your child experience anxiety? yes/no
48. Does your child ever seem irritable? yes/no
49. Has your child recently felt depressed? yes/no
50. Does your child have any behavioral problems? yes/no
51. Does your child have headaches? yes/no
52. Does your child have any allergies? yes/no
53. Has your child been diagnosed with ADHD/ADD yes/no
54. Does your child have speech problems? yes/no
55. Does your child have difficulty swallowing? yes/no
56. Has your child had his/her tonsils removed? yes/no
57. Does your child have thyroid disease? yes/no
58. Does your child have asthma? yes/no
59. Does your child have diabetes? yes/no
60. Does your child have difficulty breathing? yes/no
61. Does your child have any nasal/sinus problems? yes/no
62. Has your child ever had surgery on his/her sinuses for a sleep disorder? yes/no
63. Does your child have heartburn (acid reflux)? yes/no
64. Does your child have any neurological disorders? yes/no
65. Does your child have any neuromuscular diseases? yes/no
66. Does your child have a history of seizures? yes/no
67. Has your child had a traumatic brain injury/concussion? yes/no
68. Has your child had a spinal cord/neck injury? yes/no
69. Does your child wet the bed? yes/no
70. Does your child have any facial abnormalities? yes/no
71. Does your child drink caffeinated beverages? yes/no
    If "yes" estimate how many glasses, cups, or cans per day: _____ per day

72. Has your child previously been diagnosed with a sleep disorder? yes/no

73. Has your child ever had surgery, taken medications, or received other treatment for sleep-related problems in the past? yes/no

IF "YES" PLEASE ANSWER QUESTIONS 77-80

IF "NO" PLEASE SKIP TO QUESTION 81

74. Is your child taking medications for his/her sleep problems? yes/no
    If "yes" please list_____

75. Does your child ever use an oxygen aid while sleeping? yes/no

76. Does your child use nasal CPAP or BIPAP for sleep apnea? yes/no

77. If "yes" does he/she feel any different when using CPAP or BIPAP? yes/no
    If "yes" in what way?_____

78. Do you have any major concerns regarding your child's physical or emotional well-being or overall health due to sleep problems? yes/no

79. Does your child enjoy sleep? yes/no

80. Does he/she like to sleep late whenever he/she can? yes/no

Please use the following space to comment on anything else you would like us to know about your child's medical or sleep problems. _____