

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		

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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?

<ul style="list-style-type: none"><input type="checkbox"/> None<input type="checkbox"/> Acquired immune deficiency syndrome (AIDS)<input type="checkbox"/> AIDS related complex (ARC)<input type="checkbox"/> Any immunodeficiency syndrome<input type="checkbox"/> Chronic Lymphocytic Leukemia (CLL)<input type="checkbox"/> Congenital or hereditary immunodeficiency<input type="checkbox"/> Human Immunodeficiency Virus (HIV)<input type="checkbox"/> Leukemia within 90 days<input type="checkbox"/> Lymphocytic Leukemia within 90 days<input type="checkbox"/> Marked Neutropenia within 90 days<input type="checkbox"/> Myelodysplasia within 90 days	<ul style="list-style-type: none"><input type="checkbox"/> Myelogenic Leukemia within 90 days<input type="checkbox"/> Organ Transplant<input type="checkbox"/> Pancytopenia within 90 days<input type="checkbox"/> Prior hospitalization within 14 days<input type="checkbox"/> Radiation therapy within 90 days<input type="checkbox"/> Significant neutropenia within 90 days<input type="checkbox"/> Systemic chemotherapy within 90 days<input type="checkbox"/> Systemic corticosteroid/Prednisone therapy within 90 days<input type="checkbox"/> Systemic immunosuppressive therapy within 90 days
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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 Abdominal Circumference: _____ cm

Chest Circumference: _____ cm

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Section 3: Problems and Visit Diagnosis

Diagnosis: Why are you being seen today?

Past Medical History:

Date	Problem

Section 4: Medications/Allergies

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

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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?	<input type="checkbox"/> Yes <input type="checkbox"/> No

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Section 5: Procedures/Surgeries

Anesthesia and Transfusions:

<p>Anesthesia/Transfusions</p> <input type="checkbox"/> No anesthesia history <input type="checkbox"/> Prior anesthesia <input type="checkbox"/> Prior anesthesia reaction <input type="checkbox"/> No transfusion history <input type="checkbox"/> Prior transfusion <input type="checkbox"/> Prior transfusion reaction <input type="checkbox"/> Unknown	<p>Anesthesia Reaction(s)</p> <input type="checkbox"/> None <input type="checkbox"/> Awareness <input type="checkbox"/> Cardiac arrest <input type="checkbox"/> Difficult intubation <input type="checkbox"/> Excessive post op nausea <input type="checkbox"/> Hypertension <input type="checkbox"/> Malignant hyperthermia <input type="checkbox"/> Unknown reaction <input type="checkbox"/> Vomiting <input type="checkbox"/> Other:	<p>Blood Transfusion Acceptable</p> <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> No, except for																																										
<p>Transfusion Reaction(s)</p> <table style="width: 100%; border: none;"> <tr> <td><input type="checkbox"/> Abdominal pain</td> <td><input type="checkbox"/> Flushing</td> <td><input type="checkbox"/> Restlessness</td> </tr> <tr> <td><input type="checkbox"/> Anaphylactic reaction</td> <td><input type="checkbox"/> Generalized bleeding</td> <td><input type="checkbox"/> Rigors</td> </tr> <tr> <td><input type="checkbox"/> Anxiety</td> <td><input type="checkbox"/> Headache</td> <td><input type="checkbox"/> Tachycardia</td> </tr> <tr> <td><input type="checkbox"/> Back Pain</td> <td><input type="checkbox"/> Hemoglobinuria</td> <td><input type="checkbox"/> Tachypnea</td> </tr> <tr> <td><input type="checkbox"/> Bronchospasm</td> <td><input type="checkbox"/> Hypertension</td> <td><input type="checkbox"/> Urticaria</td> </tr> <tr> <td><input type="checkbox"/> Chest pain</td> <td><input type="checkbox"/> Hypotension</td> <td><input type="checkbox"/> Vomiting</td> </tr> <tr> <td><input type="checkbox"/> Chills</td> <td><input type="checkbox"/> Hypoxia</td> <td><input type="checkbox"/> Wheezing</td> </tr> <tr> <td><input type="checkbox"/> Cyanosis</td> <td><input type="checkbox"/> Joint pain</td> <td><input type="checkbox"/> Other:</td> </tr> <tr> <td><input type="checkbox"/> Diarrhea</td> <td><input type="checkbox"/> Nausea</td> <td></td> </tr> <tr> <td><input type="checkbox"/> Dizziness</td> <td><input type="checkbox"/> Oliguria</td> <td></td> </tr> <tr> <td><input type="checkbox"/> Dyspnea</td> <td><input type="checkbox"/> Oozing from puncture sites</td> <td></td> </tr> <tr> <td><input type="checkbox"/> Fainting</td> <td><input type="checkbox"/> Pain at insertion site</td> <td></td> </tr> <tr> <td><input type="checkbox"/> Fever</td> <td><input type="checkbox"/> Pruritus</td> <td></td> </tr> <tr> <td><input type="checkbox"/> Flank pain</td> <td><input type="checkbox"/> Rash</td> <td></td> </tr> </table>			<input type="checkbox"/> Abdominal pain	<input type="checkbox"/> Flushing	<input type="checkbox"/> Restlessness	<input type="checkbox"/> Anaphylactic reaction	<input type="checkbox"/> Generalized bleeding	<input type="checkbox"/> Rigors	<input type="checkbox"/> Anxiety	<input type="checkbox"/> Headache	<input type="checkbox"/> Tachycardia	<input type="checkbox"/> Back Pain	<input type="checkbox"/> Hemoglobinuria	<input type="checkbox"/> Tachypnea	<input type="checkbox"/> Bronchospasm	<input type="checkbox"/> Hypertension	<input type="checkbox"/> Urticaria	<input type="checkbox"/> Chest pain	<input type="checkbox"/> Hypotension	<input type="checkbox"/> Vomiting	<input type="checkbox"/> Chills	<input type="checkbox"/> Hypoxia	<input type="checkbox"/> Wheezing	<input type="checkbox"/> Cyanosis	<input type="checkbox"/> Joint pain	<input type="checkbox"/> Other:	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Nausea		<input type="checkbox"/> Dizziness	<input type="checkbox"/> Oliguria		<input type="checkbox"/> Dyspnea	<input type="checkbox"/> Oozing from puncture sites		<input type="checkbox"/> Fainting	<input type="checkbox"/> Pain at insertion site		<input type="checkbox"/> Fever	<input type="checkbox"/> Pruritus		<input type="checkbox"/> Flank pain	<input type="checkbox"/> Rash	
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<input type="checkbox"/> Flank pain	<input type="checkbox"/> Rash																																											
<p>Moderate Sedation History</p> <input type="radio"/> No prior sedation for procedure <input type="radio"/> Prior sedation for procedure <input type="radio"/> Unknown	<p>Previous Problems With Sedation</p> <input type="checkbox"/> None <input type="checkbox"/> Nausea <input type="checkbox"/> Vomiting <input type="checkbox"/> Unknown reaction <input type="checkbox"/> Other:																																											
<p>Acceptable Blood Related Products</p> <input type="checkbox"/> Albumin <input type="checkbox"/> Cryoprecipitate <input type="checkbox"/> Darbepoetin (Aranesp) <input type="checkbox"/> Erythropoietin <input type="checkbox"/> Factor IX concentrates <input type="checkbox"/> Factor VII concentrates <input type="checkbox"/> Immune globulins <input type="checkbox"/> Intraoperative cell salvage <input type="checkbox"/> Intraoperative hemodilution <input type="checkbox"/> Platelets <input type="checkbox"/> Platelet derived topical agents <input type="checkbox"/> Postoperative blood salvage/reinfusion <input type="checkbox"/> RhoGAM <input type="checkbox"/> Other:																																												

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Section 6: Family History

Relationship:	Mother	Father	Sister	Brother	Grandparent
Health Status:					
Cardiovascular:					
Aneurysm					
Heart attack					
High blood pressure					
Endocrine/Metabolic:					
Diabetes Mellitus Type I					
Diabetes Mellitus Type II					
Thyroid Disease					
Eye:					
Cataract					
Glaucoma					
Gastrointestinal:					
GERD-Gastro-esophageal reflux disease					
Hiatal Hernia					
Irritable bowel syndrome					
Liver disease					
Peptic ulcer disease					
Genitourinary:					
Enlarged prostate					
Incontinence					
Kidney disease					
Prostate cancer					
Hematologic:					
Bleeding disorder					
Hemophilia					
Immunologic:					
AIDS					
Autoimmune disease					
Musculoskeletal:					
Acute arthritis					
Back Injury					
Back Pain					
Fibromyalgia					
Osteoporosis					
Rheumatism					
Neurologic:					
Alzheimer's Disease					
Migraine					
Seizure					
Stroke					
TIA					
Tremor					

New Patient Pediatric Comprehensive Intake Form—Sleep Clinic

Oncological:	Mother	Father	Sister	Brother	Grandparent
Bladder Cancer					
Bone Tumor					
Brain Tumor					
Breast Cancer					
Colon Cancer					
Prostate Cancer					
Uterus Cancer					
Lung Cancer					
Cervix Cancer					
Ovary Cancer					
Hodgkin’s Disease					
Leukemia					
Lymphoma					
Non-Hodgkin’s Lymphoma					
Skin Cancer					
Psychiatric:					
Addiction					
Alcohol Abuse					
Anxiety					
Bipolar Disorder					
Dementia					
Depression					
Schizophrenia					
Suicidal thoughts					
Respiratory:					
Asthma					
COPD					
Sleep Apnea					
Genetic:					
Celiac Disease					
Cystic Fibrosis					
Down’s Syndrome					
Muscular dystrophy					
Exposures:					
Alcohol User					
Substance User					
Tobacco User					
OTHER:					

New Patient Pediatric Comprehensive Intake Form—Sleep Clinic

Section 7: Social 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: _____

Caffeine Use: Yes No

Type: _____ Caffeine per day: _____

Marital Status: Married Single Divorced Widowed Other: _____

Number of Children: _____

Living Arrangements:

Alone Family/Significant Other Assisted Living Other: _____

Do you have daily help needed for self-care? Yes No Name of Caregiver: _____

Activities of Daily Living: Any difficulty with? Speech or Communication Memory

Speech or Communication Memory Bathing Household Duties

Physical Activity: Exercise Type: _____ Frequency: _____

New Patient Pediatric Comprehensive Intake Form—Sleep Clinic

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
<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No

Immunizations Current: Yes No Non Received Unknown Vaccine Recommended

Other

Patient Counseled

<input type="checkbox"/> Nutrition	<input type="checkbox"/> Other:
<input type="checkbox"/> Physical activity	
<input type="checkbox"/> Elevated BMI	

Medical Devices	Durable Medical Equipment		
<input type="checkbox"/> None	<input type="checkbox"/> Oxygen therapy	<input type="checkbox"/> Commode	<input type="checkbox"/> Immobilizer
<input type="checkbox"/> Implantable cardioverter-defibrillator	<input type="checkbox"/> Walker	<input type="checkbox"/> CPAP	<input type="checkbox"/> Other:
<input type="checkbox"/> Insulin pump	<input type="checkbox"/> Wheelchair	<input type="checkbox"/> Spirometry	
<input type="checkbox"/> Medication pump	<input type="checkbox"/> Bed	<input type="checkbox"/> Splint	

New Patient Pediatric Comprehensive Intake Form—Sleep Clinic

Section 11: Pediatric Depression Screening

Complete if 12 years 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? <input type="checkbox"/> Not Difficult at all <input type="checkbox"/> Somewhat Difficult <input type="checkbox"/> Very Difficult <input type="checkbox"/> Extremely Difficult				

Pediatric Questionnaire - Sleep Clinic

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

	Yes	No		Yes	No
Pulmonary:			Gastrointestinal:		
Shortness of breath at rest	<input type="radio"/>	<input type="radio"/>	Trouble swallowing	<input type="radio"/>	<input type="radio"/>
Shortness of breath with exercise	<input type="radio"/>	<input type="radio"/>	Choking on food	<input type="radio"/>	<input type="radio"/>
Frequent cough	<input type="radio"/>	<input type="radio"/>	Heartburn	<input type="radio"/>	<input type="radio"/>
Coughing up blood	<input type="radio"/>	<input type="radio"/>	Abdominal pain	<input type="radio"/>	<input type="radio"/>
Chest pain	<input type="radio"/>	<input type="radio"/>	Nausea	<input type="radio"/>	<input type="radio"/>
Wake up at night short of breath	<input type="radio"/>	<input type="radio"/>	Vomiting	<input type="radio"/>	<input type="radio"/>
Recurrent chest infections	<input type="radio"/>	<input type="radio"/>	Diarrhea	<input type="radio"/>	<input type="radio"/>
Exposure to tuberculosis	<input type="radio"/>	<input type="radio"/>	Ulcers	<input type="radio"/>	<input type="radio"/>
Wheezing	<input type="radio"/>	<input type="radio"/>	Jaundice	<input type="radio"/>	<input type="radio"/>
Blood clot in legs or lungs	<input type="radio"/>	<input type="radio"/>	Renal:		
Cardiac:			Blood in urine	<input type="radio"/>	<input type="radio"/>
High blood pressure	<input type="radio"/>	<input type="radio"/>	Urinary tract infections	<input type="radio"/>	<input type="radio"/>
Heart attack	<input type="radio"/>	<input type="radio"/>	Kidney stones	<input type="radio"/>	<input type="radio"/>
Leg swelling	<input type="radio"/>	<input type="radio"/>	Frequent urination at night	<input type="radio"/>	<input type="radio"/>
Heart racing or thumping	<input type="radio"/>	<input type="radio"/>	Painful urination	<input type="radio"/>	<input type="radio"/>
Rheumatic fever	<input type="radio"/>	<input type="radio"/>	Neurologic:		
Needs to sleep on 2 or more pillows	<input type="radio"/>	<input type="radio"/>	Stroke	<input type="radio"/>	<input type="radio"/>
High cholesterol	<input type="radio"/>	<input type="radio"/>	Migraines	<input type="radio"/>	<input type="radio"/>
Constitutional symptoms:			Frequent headaches	<input type="radio"/>	<input type="radio"/>
Fever	<input type="radio"/>	<input type="radio"/>	Numbness or tingling	<input type="radio"/>	<input type="radio"/>
Night sweats	<input type="radio"/>	<input type="radio"/>	Seizure	<input type="radio"/>	<input type="radio"/>
Chills	<input type="radio"/>	<input type="radio"/>	Dizziness	<input type="radio"/>	<input type="radio"/>
Weight loss	<input type="radio"/>	<input type="radio"/>	Imbalance or unsteadiness	<input type="radio"/>	<input type="radio"/>
Musculoskeletal:			Vertigo	<input type="radio"/>	<input type="radio"/>
Muscle weakness	<input type="radio"/>	<input type="radio"/>	Hematology/Oncologic:		
Joint pain	<input type="radio"/>	<input type="radio"/>	Anemia	<input type="radio"/>	<input type="radio"/>
Joint swelling	<input type="radio"/>	<input type="radio"/>	Cancer	<input type="radio"/>	<input type="radio"/>
Psychiatric:			Bleeding tendency	<input type="radio"/>	<input type="radio"/>
Depression	<input type="radio"/>	<input type="radio"/>	Blood transfusion	<input type="radio"/>	<input type="radio"/>
Anxiety	<input type="radio"/>	<input type="radio"/>	ENT:		
Poor sleep	<input type="radio"/>	<input type="radio"/>	Blurred vision	<input type="radio"/>	<input type="radio"/>
Snoring	<input type="radio"/>	<input type="radio"/>	Decreased hearing	<input type="radio"/>	<input type="radio"/>
Morning headaches or awakening	<input type="radio"/>	<input type="radio"/>	Frequent sore throat	<input type="radio"/>	<input type="radio"/>
Excessive sleep during day	<input type="radio"/>	<input type="radio"/>	Sinus infections	<input type="radio"/>	<input type="radio"/>
Panic attacks	<input type="radio"/>	<input type="radio"/>	Hay fever	<input type="radio"/>	<input type="radio"/>
			Hoarseness	<input type="radio"/>	<input type="radio"/>

PEDIATRIC SLEEP HISTORY

This questionnaire will provide the Sleep Disorders Program with a better understanding about your child's case. Please answer all questions to the best of your ability. If any questions are not applicable please leave them blank.

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:
per night _____ times
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?
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?
If "yes" estimate how long: _____ months
17. Does your child grind his/her teeth during sleep?
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

New Patient Pediatric Comprehensive Intake Form—Sleep Clinic

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

New Patient Pediatric Comprehensive Intake Form—Sleep Clinic

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

New Patient Pediatric Comprehensive Intake Form—Sleep Clinic

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. _____

