Enticare
PEDIATRIC SLEEP QUESTIONNAIRE

CHILD'S NAME: ________________________________ DOB: ______________ AGE: _____

CURRENT WEIGHT _______ CURRENT HEIGHT ______

SLEEP COMPLAINT(S)

____

MATERNAL INFORMATION

AGE: _______

RECEIVED PRENATAL CARE? YES NO

BEGINNING AT _______ WEEKS WEEKS OF PREGNANCY: ______

DELIVERY: _______ VAGINAL _______ C-SECTION

PLEASE LIST ANY COMPLICATIONS OF YOUR PREGNANCY OR DELIVERY

____

DID YOU TAKE ANY MEDICATIONS DURING YOUR PREGNANCY? YES NO

IF YES, PLEASE LIST: ____

DO YOU CURRENTLY SMOKE? YES NO

IF YES, HOW MANY PER DAY _______

DID YOU SMOKE DURING YOUR PREGNANCY? YES NO

DO ANY OTHER FAMILY MEMBERS CURRENTLY SMOKE AROUND YOUR CHILD? YES NO

IF YES, AMOUNT _______

ALCOHOL CONSUMPTION DURING PREGNANCY? YES NO

TYPE _________________ AMOUNT PER DAY ___________

CAFFEINE INTAKE:

DURING PREGNANCY: COFFEE ______ (AMT) SODA ______ (AMT)

DURING BREASTFEEDING: COFFEE ______ (AMT) SODA ______ (AMT)

ARE YOU CURRENTLY BREASTFEEDING? YES NO

FAMILY HISTORY

DO YOU HAVE OTHER CHILDREN WITH SLEEP PROBLEMS? YES NO

EXPLAIN: ______________________________

ARE THERE PARENTAL CONFLICTS REGARDING MANAGEMENT OF YOUR CHILD'S SLEEP PROBLEM? YES NO

EXPLAIN: ______________________________

DOES ANYONE IN YOUR FAMILY SNORE OR HAVE A DIAGNOSIS OF SLEEP APNEA? YES NO

HAVE YOU HAD ANY CHILDREN THAT HAVE NOT SURVIVED? YES NO

PLEASE PROVIDE THE AGE AND CIRCUMSTANCE OF DEATH ______________

____

INFANT/PATIENT INFORMATION

DID YOUR CHILD HAVE ANY ABNORMALITIES PRESENT AT BIRTH? YES NO

EXPLAIN: ______________________________

DOES YOUR CHILD CURRENTLY HAVE ANY HEALTH PROBLEMS? YES NO

EXPLAIN: ______________________________

LIST ANY MEDICATIONS YOUR CHILD IS CURRENTLY TAKING:

____

HAS YOUR CHILD USED A HOME MONITOR YES NO

MANUFACTURER? ______________________________

PLEASE DESCRIBE ANY ALARMS OR EVENTS: ______________

____

HAS YOUR CHILD ANY SURGERIES?
(TONSILLECTOMY, ADOIDECTOMY, OTHER) YES NO

____

HAVE YOU EVER NOTICED, OR BEEN TOLD, THAT YOUR CHILD HAS ANY OF THE FOLLOWING?

	YES	NO
BLUISH COLOR AROUND LIPS OR FINGERNAILS		
STOPPING BREATHING		
VOMITING OR SPITTING UP DURING SLEEP		
EXCESSIVE VOMITING/SPITTING UP DURING WAKE		
LOUD SNORING		
FREQUENT NIGHTTIME AWAKENINGS		
HEAD BANGING		
NIGHT TERRORS (SCREAMING, POUNDING HEART, NON-RESPONSIVE)		
REQUIRED RESUSCITATIVE MEASURES		
ENLARGED TONSILS		
WHEEZING		
FAILURE TO GAIN WEIGHT		
COLIC		
EXCESSIVE IRRITABILITY		
FEEDING DIFFICULTIES (CHOKING, COUGHING, TURNING BLUE)		
EXCESSIVE NIGHTTIME SWEATS		
VERY DISTURBED BEDDING		
CHRONIC EAR INFECTIONS		
OTHER (Please describe):		

NIGHTTIME BEHAVIORS

NORMAL BEDTIME ____________ NUMBER OF HOURS PER NIGHT ______________

NIGHT FEEDINGS (amt/times) ______________

HOW DOES YOUR INFANT/CHILD FALL ASLEEP? ______________________________

WHERE DOES YOUR CHILD SLEEP AT NIGHT? ________________________________

DOES YOUR CHILD NAP? YES NO

WHERE DOES YOUR CHILD NAP? ______________________________

AT WHAT AGE DID YOUR CHILD BEGIN SLEEPING THROUGH THE NIGHT? ________

SLEEP ENVIRONMENT (please describe) ______________________________

WHAT POSITION DOES YOUR CHILD SLEEP IN? ______________________________

DOES YOUR CHILD USE A PACIFIER? YES NO

DOES YOUR CHILD USE SPECIAL ITEM(S) THAT AID IN SLEEP? YES NO

Policy and Procedure: Epworth Sleepiness Scale
Policy #: OS6.3
Effective Date: 9/29/11
Last Revision Date:
Category: Office and Scheduling Procedures
Approved:

THE EPWORTH SLEEPINESS SCALE

Please answer the questions below and return to your physician

Even, if you have not performed the tasks below as of late, think about how they may have affected you in the past. How likely are you to doze off or fall asleep in the following situations?

Use the following scale to choose the most appropriate number for each situation:

0 = no chance of dozing
1 = slight chance of dozing
2 = moderate chance of dozing
3 = high chance of dozing

SITUATION	CHANCE OF DOZING
Sitting and reading	
Watching TV	
Sitting inactive in a public place (e.g., a theater or a meeting)	
As a passenger in a car for an hour without a break	
Lying down to rest in the afternoon when circumstances permit	
Sitting and talking to someone	
Sitting quietly after a lunch without alcohol	
In a car, while stopped for a few minutes in traffic	

Name:____________________________ Phone:__________________
Date:____________________