



COMER CHILDREN'S HOSPITAL  
THE UNIVERSITY OF CHICAGO

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### Section of Pediatric Sleep Medicine

Date: \_\_\_\_\_

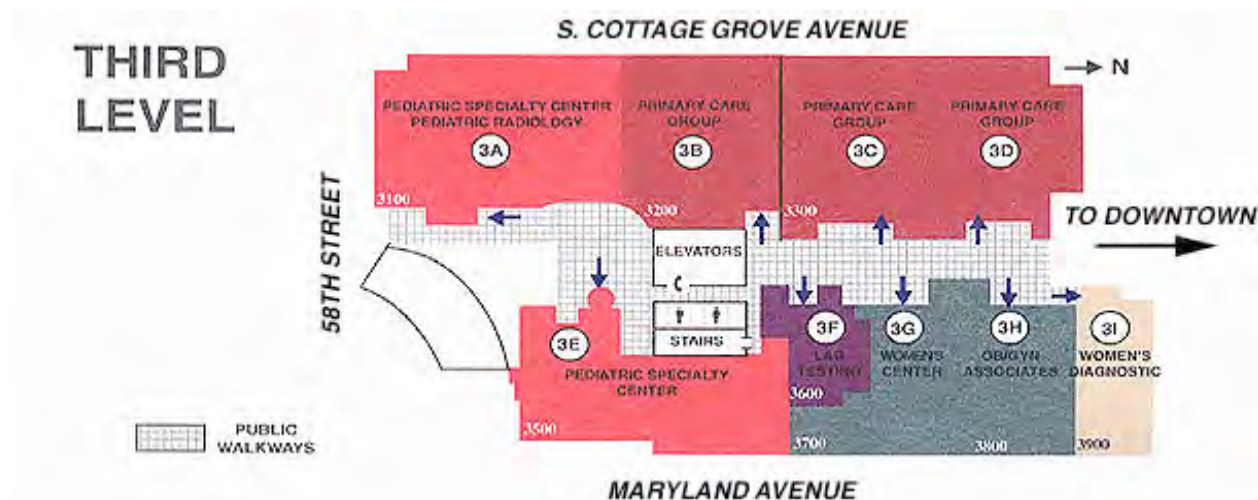
Dear Parent or Caregiver;

Thank you for your interest in the Sleep Disorders Program. The sleep clinic's standard assessment procedure includes completion of the enclosed intake questionnaire and sleep diary. **Please bring the completed forms to your sleep clinic appointment on**

\_\_\_\_\_ at \_\_\_\_\_.

Completion of the intake questionnaire (eight pages) and sleep diary (one page) is *critical* in evaluating your child's sleep habits. *Please begin recording your child's sleep schedule.*

The sleep clinic is located in the Duchossois Center for Advance Medicine (DCAM building) 5758 S. Maryland Avenue Pediatric Area located on the 3<sup>rd</sup> Floor **Area 3A**.



Once again, thank you for your interest in our pediatric sleep medicine clinic. We look forward to assisting you and your child. Please call 773-702-6169 if you have questions about your first appointment or how to complete the enclosed forms.



**PLEASE DESCRIBE IN YOUR OWN WORDS YOUR CHILD'S MAIN SLEEP PROBLEM?**

How many years has this been a problem?

① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩

Other: \_\_\_\_\_

Does your child fall asleep alone in bed?

Never

Rarely

Occasionally

Frequently

Always

☐

☐

☐

☐

☐

What type of bed does your child sleep in?

Crib

Single Bed

Double Bed

Other: \_\_\_\_\_

☐

☐

☐

☐

Does your child sleep alone in their bed?

Never

Rarely

Occasionally

Frequently

Always

☐

☐

☐

☐

☐

If not, with who?

Does your child share their bedroom with someone else?

Yes

No

☐

☐

If so, with who?

**Weekdays**

**Weekends**

What time is the bedroom light turned off?

On average, how long does it take your child to fall asleep?

What time does your child wake up in the morning?

What time is your child out of bed in the morning?

*Number of hours of sleep.*

Does your child wake up spontaneously/ on their own?

Never

Rarely

Occasionally

Frequently

Always

☐

☐

☐

☐

☐

In the last two weeks, what is the quickest time it has taken your child to fall asleep?

What was the longest time?

What do you think prevents your child from falling asleep?

Fears

Loneliness

Not Sleepy

Worries

☐

☐

☐

☐

Other: \_\_\_\_\_

Do you get annoyed/angry when your child can't sleep?

Never

Rarely

Occasionally

Frequently

Always

☐

☐

☐

☐

☐



How many days a week does your child cry in bed in order to get to sleep?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	0	1	2	3	4
Is your child bothered by environmental noises?	Never <input type="radio"/>	Rarely <input type="radio"/>	Occasionally <input type="radio"/>	Frequently <input type="radio"/>	Always <input type="radio"/>
Does your child drink any tea/coffee in the evening?	Never <input type="radio"/>	Rarely <input type="radio"/>	Occasionally <input type="radio"/>	Frequently <input type="radio"/>	Always <input type="radio"/>
Does your child drink any caffeinated beverages in the evening? - e.g. Cola, Mountain Dew, Red Bull	Never <input type="radio"/>	Rarely <input type="radio"/>	Occasionally <input type="radio"/>	Frequently <input type="radio"/>	Always <input type="radio"/>
Does your child read in bed before bedtime?	Never <input type="radio"/>	Rarely <input type="radio"/>	Occasionally <input type="radio"/>	Frequently <input type="radio"/>	Always <input type="radio"/>
Does your child watch TV in the bedroom before bedtime?	Never <input type="radio"/>	Rarely <input type="radio"/>	Occasionally <input type="radio"/>	Frequently <input type="radio"/>	Always <input type="radio"/>
Does your child use the Computer in the bedroom before bedtime?	Never <input type="radio"/>	Rarely <input type="radio"/>	Occasionally <input type="radio"/>	Frequently <input type="radio"/>	Always <input type="radio"/>
Does your child listen to the radio in the bedroom before bedtime?	Never <input type="radio"/>	Rarely <input type="radio"/>	Occasionally <input type="radio"/>	Frequently <input type="radio"/>	Always <input type="radio"/>
Does your child use the phone in the bedroom before bedtime?	Never <input type="radio"/>	Rarely <input type="radio"/>	Occasionally <input type="radio"/>	Frequently <input type="radio"/>	Always <input type="radio"/>
When unable to fall asleep, does your child get out of bed?	Never <input type="radio"/>	Rarely <input type="radio"/>	Occasionally <input type="radio"/>	Frequently <input type="radio"/>	Always <input type="radio"/>
If so, how long after getting in to bed?	_____ Hours _____ Minutes				
How long does your child stay up for after getting out of bed?	_____ Hours _____ Minutes				
How many times does your child wake up through the night?	0	1	2	3	4
	5	6	7	8	9
	10	Other: _____			
How long does it take for your child to fall asleep after awakening?	_____ Hours _____ Minutes				
<b>SLEEP DESCRIPTION</b>					
Does your child snore at night?	Never <input type="radio"/>	Rarely <input type="radio"/>	Occasionally <input type="radio"/>	Frequently <input type="radio"/>	Always <input type="radio"/>
How many nights does your child snore (per week)?	0	1	2	3	4
	5	6	7		
Does your child ever seem to stop breathing while asleep?	Never <input type="radio"/>	Rarely <input type="radio"/>	Occasionally <input type="radio"/>	Frequently <input type="radio"/>	Always <input type="radio"/>



How loud is the snore?	Mildly Quiet <input type="radio"/>	Medium Loud <input type="radio"/>	Loud <input type="radio"/>	Very Loud <input type="radio"/>	Extremely Loud <input type="radio"/>
Do you ever shake your child to help them breathe?	Never <input type="radio"/>	Rarely <input type="radio"/>	Occasionally <input type="radio"/>	Frequently <input type="radio"/>	Always <input type="radio"/>
Does your child sweat profusely at night?	Never <input type="radio"/>	Rarely <input type="radio"/>	Occasionally <input type="radio"/>	Frequently <input type="radio"/>	Always <input type="radio"/>
Do your child's lips turn blue or purple while asleep?	Never <input type="radio"/>	Rarely <input type="radio"/>	Occasionally <input type="radio"/>	Frequently <input type="radio"/>	Always <input type="radio"/>
Does your child sleep with their mouth open?	Never <input type="radio"/>	Rarely <input type="radio"/>	Occasionally <input type="radio"/>	Frequently <input type="radio"/>	Always <input type="radio"/>
Does your child complain of dry mouth during the night?	Never <input type="radio"/>	Rarely <input type="radio"/>	Occasionally <input type="radio"/>	Frequently <input type="radio"/>	Always <input type="radio"/>
Does your child grind their teeth through the night?	Never <input type="radio"/>	Rarely <input type="radio"/>	Occasionally <input type="radio"/>	Frequently <input type="radio"/>	Always <input type="radio"/>
Does your child wet the bed?	Yes <input type="radio"/>	No <input type="radio"/>			
If so, how many times a week?	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4 <input type="radio"/> 5 <input type="radio"/> 6 <input type="radio"/> 7				
Has your child ever been consistently dry through the night (> 3 months)?	Yes <input type="radio"/>	No <input type="radio"/>			
Does your child toss and turn in bed?	Never <input type="radio"/>	Rarely <input type="radio"/>	Occasionally <input type="radio"/>	Frequently <input type="radio"/>	Always <input type="radio"/>
Does your child rock their head or body from side to side at night?	Never <input type="radio"/>	Rarely <input type="radio"/>	Occasionally <input type="radio"/>	Frequently <input type="radio"/>	Always <input type="radio"/>
Does your child complain of aching legs at bedtime?	Never <input type="radio"/>	Rarely <input type="radio"/>	Occasionally <input type="radio"/>	Frequently <input type="radio"/>	Always <input type="radio"/>
Does your child's leg jerks while he is asleep at night?	Never <input type="radio"/>	Rarely <input type="radio"/>	Occasionally <input type="radio"/>	Frequently <input type="radio"/>	Always <input type="radio"/>
Does your child have 'crawling sensations' in their legs during the day?	Never <input type="radio"/>	Rarely <input type="radio"/>	Occasionally <input type="radio"/>	Frequently <input type="radio"/>	Always <input type="radio"/>
Does your child have a constant need to move their feet during the day/night?	Never <input type="radio"/>	Rarely <input type="radio"/>	Occasionally <input type="radio"/>	Frequently <input type="radio"/>	Always <input type="radio"/>
Does your child have nightmares?	Never <input type="radio"/>	Rarely <input type="radio"/>	Occasionally <input type="radio"/>	Frequently <input type="radio"/>	Always <input type="radio"/>
Does your child ever awaken suddenly	Never <input type="radio"/>	Rarely <input type="radio"/>	Occasionally <input type="radio"/>	Frequently <input type="radio"/>	Always <input type="radio"/>



with a scream and appear inconsolable?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
If so, how many times per week?	① ② ③ ④ ⑤ ⑥ ⑦				
What time of night does this occur?					
Does your child sleep walk?	Never <input type="radio"/>	Rarely <input type="radio"/>	Occasionally <input type="radio"/>	Frequently <input type="radio"/>	Always <input type="radio"/>
How many times per week?	① ② ③ ④ ⑤ ⑥ ⑦				
If your child sleepwalks, has he/she ever injured himself/herself?	Never <input type="radio"/>	Rarely <input type="radio"/>	Occasionally <input type="radio"/>	Frequently <input type="radio"/>	Always <input type="radio"/>
Does your child talk in their sleep?	Never <input type="radio"/>	Rarely <input type="radio"/>	Occasionally <input type="radio"/>	Frequently <input type="radio"/>	Always <input type="radio"/>

## DAYTIME DESCRIPTION

When your child is awake in the morning how do they feel?	Refreshed <input type="radio"/>	Tired/Sleepy <input type="radio"/>	Irritable <input type="radio"/>		
Does your child have headaches first thing in the morning?	Yes <input type="radio"/>	No <input type="radio"/>			
If so, how many days a week?	① ② ③ ④ ⑤ ⑥ ⑦				
Is your child sleepy during the day?	Never <input type="radio"/>	Rarely <input type="radio"/>	Occasionally <input type="radio"/>	Frequently <input type="radio"/>	Always <input type="radio"/>
Does your child take naps during the day?	Never <input type="radio"/>	Rarely <input type="radio"/>	Occasionally <input type="radio"/>	Frequently <input type="radio"/>	Always <input type="radio"/>
If so, how many per day?					
How many naps per day?					
In the following situations, what are the chances of your child falling asleep (please check)?					
<b>Situation</b>	No chance	Slight Chance	Moderate Chance	High Chance	
Sitting and Reading					
Watching TV					
Sitting inactive in a public place(e.g. theater)					
As a passenger in a car for					



hour with no break				
Lying down in the afternoon				
Sitting and Talking to someone				
Sitting quietly after lunch				
In a car, while stopped for few minutes in traffic				

*Modified Epworth Sleepiness Scale Score*

Has the teacher been concerned about your child being sleepy or inattentive at school?	Yes <input type="radio"/>	No <input type="radio"/>			
Has your child fallen asleep at school?	Never <input type="radio"/>	Rarely <input type="radio"/>	Occasionally <input type="radio"/>	Frequently <input type="radio"/>	Always <input type="radio"/>
What time of day does your child seem most alert?	AM <input type="radio"/>	PM <input type="radio"/>			
Do you consider your child's sleep problem to be:	Mild <input type="radio"/>	Moderate <input type="radio"/>	Severe <input type="radio"/>		
Have you ever used medications to aid in your child's sleep?	Yes <input type="radio"/>	No <input type="radio"/>			
If so, please list what drug and when?					

**Past Medical History:** Does your child have or have had any of the following:

Was your child born premature?	Yes <input type="radio"/>	No <input type="radio"/>
If so, how many weeks premature?		
Did your child have colic as an infant?	Yes <input type="radio"/>	No <input type="radio"/>
Head Injury	Yes <input type="radio"/>	No <input type="radio"/>
Seizures	Yes <input type="radio"/>	No <input type="radio"/>
Meningitis	Yes <input type="radio"/>	No <input type="radio"/>
Visual Problems	Yes <input type="radio"/>	No <input type="radio"/>
Hearing Problems	Yes <input type="radio"/>	No <input type="radio"/>



Recurrent Ear Infections (>5/yr)	Yes <input type="radio"/>	No <input type="radio"/>
Recurrent Throat Infections/Tonsillitis(>5/yr)	Yes <input type="radio"/>	No <input type="radio"/>
Speech Problems	Yes <input type="radio"/>	No <input type="radio"/>
Allergies / Chronic Nasal Congestion	Yes <input type="radio"/>	No <input type="radio"/>
Elevated Thyroid Function	Yes <input type="radio"/>	No <input type="radio"/>
Reduced Thyroid Function	Yes <input type="radio"/>	No <input type="radio"/>
Asthma	Yes <input type="radio"/>	No <input type="radio"/>
Chronic Breathing Disorder	Yes <input type="radio"/>	No <input type="radio"/>
If so: please specify		
RSV Infection	Yes <input type="radio"/>	No <input type="radio"/>
Heart Problems	Yes <input type="radio"/>	No <input type="radio"/>
If so: please specify		
Elevated Cholesterol	Yes <input type="radio"/>	No <input type="radio"/>
High Blood Pressure	Yes <input type="radio"/>	No <input type="radio"/>
Constipation	Yes <input type="radio"/>	No <input type="radio"/>
Gastrointestinal Problems	Yes <input type="radio"/>	No <input type="radio"/>
If so: please specify		
Arthritis	Yes <input type="radio"/>	No <input type="radio"/>
Eczema	Yes <input type="radio"/>	No <input type="radio"/>
Neurological Problems	Yes <input type="radio"/>	No <input type="radio"/>
If so: please specify		
Developmental Delay:	Yes <input type="radio"/>	No <input type="radio"/>
Allergies		
Has your child been formally allergy tested?	Yes <input type="radio"/>	No <input type="radio"/>
Does your child have a drug allergy?	Yes <input type="radio"/>	No <input type="radio"/>
What are the known drug allergies?		
Does you child have a food or environmental allergy?	Yes <input type="radio"/>	No <input type="radio"/>
What are the known food/environmental allergies?		
Immunization Status Up To Date?	Yes <input type="radio"/>	No <input type="radio"/>
Has your child had any surgeries?	Yes <input type="radio"/>	No <input type="radio"/>



Has your child had a tonsillectomy?	Yes <input type="radio"/>	No <input type="radio"/>
Has your child had an adenoidectomy?	Yes <input type="radio"/>	No <input type="radio"/>
Has your child had ear tubes placed?	Yes <input type="radio"/>	No <input type="radio"/>
Other Surgeries: please specify		
Is your child on medications?	Yes <input type="radio"/>	No <input type="radio"/>
Please list what medication, what dose, and when?		
Please complete the following		
	Age	Illness
Mother		
Father		
Brother (s)		
Sister (s)		
Does anyone in the family have obstructive sleep apnea or use CPAP/BIPAP?	Yes <input type="radio"/>	No <input type="radio"/>
If so who?		
Does anyone in the family have restless leg syndrome?	Yes <input type="radio"/>	No <input type="radio"/>
If so, who?		
Does anyone in the family have narcolepsy?	Yes <input type="radio"/>	No <input type="radio"/>
If so, who?		



Does anyone smoke in the family?	Yes <input type="radio"/>	No <input type="radio"/>	
If so, who?	Father <input type="radio"/>	Mother <input type="radio"/>	Siblings <input type="radio"/>
Are there cats at your home?	Yes <input type="radio"/>	No <input type="radio"/>	
Are there dogs at your home?	Yes <input type="radio"/>	No <input type="radio"/>	
Any other pets: please specify:			
Is the home carpeted?	Yes <input type="radio"/>	No <input type="radio"/>	
Is your child's bedroom carpeted?	Yes <input type="radio"/>	No <input type="radio"/>	
Do you use dust mite covers?	Yes <input type="radio"/>	No <input type="radio"/>	
Please list any illnesses that run in the family, such as diabetes, hypertension, heart disease, psychiatric			
Condition	Family Member		

## TWO-WEEK SLEEP DIARY



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↑

\_\_\_\_\_

Mid-

[illegible]