Pediatric Neurologists of Palm Beach
Sleep Medicine Clinic

Technician Contact: Carlos or Jaimie: 786.597.4990

Date: _____

Patient Information

Full Name: _____
Last *First* *M.I.*

Date of Birth: _____
Month *Day* *Year*

Referring physician: _____
Last *First* *City*

☐ Female ☐ Male

Clinical Information

What are your major concerns regarding your or your child's sleep?

What have you tried in the past to help?

Last Name: _____

Do you/your child have a history of:

☐	Attention Deficit	☐	School/Learning Difficulties	☐	Behavioral Difficulties	☐	Developmental Delays or Intellectual Disabilities
☐	Autistic Spectrum	☐	Bipolar Disorder or Depression	☐	Drug/Alcohol Abuse	☐	Frequent or Severe Headaches
☐	Head Trauma	☐	Seizures	☐	Neuromuscular Disease	☐	GERD/reflux
☐	Heart problems	☐	Asthma	☐	Allergies/Sinus Problems	☐	Frequent ear infections

Have you/your child ever had:

☐	Tonsils Removed	☐	Adenoids Removed	☐	Ear Tubes	☐	Other Head or Neck Surgery

Birth History

Birth weight: _____

Was your child born prematurely? ☐ No ☐ Yes If yes, how many weeks _____

List any complications with the pregnancy, labor or delivery

Please list any other significant or pertinent medical problems:

Please list all medications you/your child takes:

Does anyone in the family have a history of:

☐	Bipolar Disorder	☐	Narcolepsy	☐	Restless Legs Syndrome	☐	Neuromuscular Disorders
☐	Autistic Spectrum	☐	Thyroid Disease	☐		☐	

Last Name: _____

Sleep History
On school days, what time do you/your child: **go to sleep? _____wake up? _____**
On weekends, what time to you/your child: **go to sleep? _____wake up? _____**
How long does it usually take to fall asleep? ☐ 5 minutes or less ☐ 30 minutes or less ☐ 30-60 minutes ☐ over an hour ☐ several hours
How often do you/your child take naps? ☐ More than once a day ☐ Every day ☐ Several time a week, ☐ Once a week or less ☐ Never
If several times a week or more, how long is a typical nap? ☐ 30 minutes or less ☐ 30-60 minutes ☐ over an hour ☐ several hours
How often do you/your child drink caffeinated beverages? ☐ every day ☐ several times a week ☐ once a week or less
How often do you/your child get exercise? ☐ every day ☐ several times a week ☐ once a week or less

	Yes	No
Is there a regular bedtime routine?		
Does the child have his/her own bedroom?		
Does the child have his/her own bed?		
Is there a parent present when your child falls asleep?		
Does the child resist going to bed?		
Does the child have difficulty falling asleep?		
Does the child awaken during the night?		
Is this a problem?		
If awakening at night, does the child have difficulty returning to sleep?		
Is the child difficult to awaken in the morning?		
Is the child a poor sleeper?		

Last Name: _____

Do you/your child have:	Never	Sometimes	Often
Difficulty Breathing when asleep?			
Stops breathing during sleep?			
Snores?			
Restless sleep?			
Sweating when sleeping?			
Daytime sleepiness?			
Poor appetite?			
Nightmares?			
Sleepwalking?			
Sleeptalking?			
Screaming during sleep?			
Leg kicking during sleep?			
Waking up at night?			
Getting out of bed at night?			
Trouble staying in his/her bed?			
Resistance going to bed?			
Teeth grinding?			
Uncomfortable "creepy-crawly" feeling in his/her legs?			
Bed wetting?			

Do you/your child:	Never	Sometimes	Often
Have trouble getting up in the morning			
Fall asleep at school			
Nap after school			
Have daytime sleepiness			
Feel weak or lose muscle control with strong emotions			
Is unable to move when falling asleep or awakening			
Sees frighting images when falling asleep or awakening			

Last Name: _____

Circle the number that describes the likelihood that you/your child would fall asleep in the following circumstances

0=would never doze or sleep
1=slight chance of dozing or sleeping
2=moderate chance of dozing or sleeping
3=high chance of dozing or sleeping.

Sitting and reading	0	1	2	3
Watching television	0	1	2	3
Sitting inactive in a public place (for example, a movie theater or classroom)	0	1	2	3
As a passenger in a car for an hour without a break	0	1	2	3
Lying down to rest in the afternoon when circumstances permit	0	1	2	3
Sitting and talking to someone	0	1	2	3
Sitting quietly after lunch	0	1	2	3
Doing homework or taking a test	0	1	2	3

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☐ Female	☐ Male		

To be completed prior to sleep study			
What is your/your child's usual bed time?		Usual wake up time?	
What time did you/your child go to bed last night?		What time did you/your child wake up this morning?	
List all medications taken today and the times they were taken			
List any medications you/your child normally takes before bed			

To be completed after the sleep study

1. How did you/your child sleep last night?

☐ better than usual ☐ same as usual ☐ worse than usual

2. If better or worse, in what way?

3. This morning, do you/your child feel:

☐ more alert than usual ☐ same as usual ☐ less alert than usual

4. With regard to sleep events such as snoring, breathing irregularities, night terror/nightmares, bed wetting, etc…

a. Please describe anything that occurred last night that usually does not occur at home?

b. Please describe anything that usually occurs at home that did not occur last night?

5. Please list any circumstances that may have affected the way you/your child normally sleeps (for example, normally sleeps with their favorite blanket, stuffed animal, pet, night light, music, siblings, etc)

6. If you have any other comments about the study please write them below. You may also (561) 753-888 and speak confidentially with Michelle Pietanza