Emerald Coast Pediatric Sleep Consultants, LLC

Pediatric History for Sleep Study Patients

Name of Child: _____ **SSN:**_____
Last First Middle

Date of Birth: ____/____/____ **Place of Birth:** **Hospital:**_____
City/State:_____

Child's Address: _____
Street Apt. City State Zip

Home Phone Number: ( )_____ **Cell Phone Number:** ( )_____

Work Phone Number: ( )_____ **To Leave Messages:** ( )_____
What is this person's name? _____

Please complete this section for all people who live in the same household as the child.

Full Name	How Related	Age	Work	Education

Who has legal custody of the child? _____ **Relationship**_____

Who is the child's primary doctor? _____
Name Phone

Do other doctors also see the child? If so, please list them.

Name of Doctor	Address	Phone Number	Why does child see this doctor?

What pharmacy do you usually use? _____ ( )_____
Name Location Phone

Patient Name:_____ **DOB:**_____

General History

Biological Mother's Pregnancy History:
Total number of pregnancies:_____ This was pregnancy number: _____
Did mom have any miscarriages? _____ If yes, how many? _____

Please check the box if any of the following problems occurred during the pregnancy of the child we are seeing today.

Unusual swelling	Unusual weight gain	High blood pressure
Infection	Unusual vomiting	Bleeding
Alcohol use	Tobacco use	Drug use

Child's History:

Birth
Early? _____ Late? _____ On time? _____
Weeks Weeks

Birth weight: _____pounds _____ounces APGAR scores (if known): _____ _____
1 min 5 min

Was labor induced? ____ If yes, why? _____
Vaginal delivery? _____ C-section? _____ Why? _____
Please describe any problems the baby had immediately after birth: _____
_____

Please check the box if any of the following problems occurred during the first year of your child's life.

Problems sucking	Choking	Lots of spitting / vomiting
Poor eating	Seemed stiff	Seemed limp
Cried a lot	Seemed too quiet	Didn't gain enough weight

Describe any other problems during the first year of your child's life: _____
_____

At what age did your child first do each of these things? (Patients under 2 years only). If over age 2, please check one: _____normal development or ____ developmental delay.

Hold head up	Roll over	Sit alone
Crawl	Pull up	Walk
Feed self	Speak first word	Use sentences
Dress self	Have bladder control	Have bowel control

Did your child ever lose any developmental milestones? When? _____
_____

Patient Name:_____ **DOB:**_____

Behavior: Describe any unusual behavioral concerns or problems with your child:

_____

Please tell us about all the medicines and supplements your child takes at this time.

Name of medicine	Amount taken	How often	What for

Please tell us about all the medicines or supplements your child has taken in the past.

Name of medicine	Why taken	When start / stop	Why stopped

Please tell us about any hospitalizations or surgeries your child has had. Be sure to include any ENT or lung procedures.

Date of stay/ surgery	Name of hospital	Reason for hospitalization	Surgery performed

Are your child's immunizations up to date? Yes_____ No _____

Does your child have any allergies?

Allergy	Reaction

Patient Name:_____ **DOB:**_____

ENT / Respiratory History
Does your child have any of the following problems?

Problem	Present	Not Present
Frequent nasal congestion		
Trouble breathing through nose		
Sinus problems		
Chronic bronchitis /cough		
Snoring during sleep		
Allergies		
Asthma		
Frequent colds / flu		
Frequent ear infections		
Frequent throat infections		
Difficulty swallowing		
Hearing problems		
Speech problems		
Problems with facial bones or structure		
Other		
Other		

Does your child have any other medical problems?

System	Type of problem(s) or describe
Heart	
Skin	
Psych / emotional	
Stomach/intestines (including acid reflux)	
Kidneys/bladder	
Blood	
Immune system/infection	
Muscles / bones	
Seizures / head injury	
Poor or delayed growth	
Excessive weight	
Morning headaches	
High blood pressure	
Genetic disease	
Thyroid problems	
Pain	
Other	

Patient Name:_____ **DOB:**_____

Please check the box and write if anyone on either side of the family has these problems.

Headaches	Thyroid disease	Intellectual disability or slow development
Anemia or low iron	Sleep talking	Tics
ADHD / ADD	Psychiatric problems	Seizures
Insomnia/ Problems falling asleep	Sleep apnea / CPAP	Restless leg syndrome
Narcolepsy/ Sleeping too much	Sleepwalking	Snoring

Please tell us about your child's school or day care.

Name and city where located	
Grade or program your child is in	
How are your child's grades in school?	
Receiving any special services? What type?	
Results of any special testing performed	

Please list any significant life changes or social stressors (good or bad) that have affected your child in the past 6-12 months: _____
_____

Sleep History

What are your major concerns about your child's sleep? _____
_____
What things have you tried to help your child's sleep problem? _____
_____

Does your child drink caffeinated beverages (i.e. Coke, Pepsi, tea, Mountain Dew, coffee, energy drinks) ? Yes _____ (Amount per day _____) No _____

What is your child's bedtime Monday – Friday? _____
What time do they usually wake up? _____

Patient Name:_____ **DOB:**_____

What is your child's bedtime on weekends and vacation? _____
What time do they usually wake up? _____
How long does it typically take your child to fall asleep? _____
How many naps does your child take during the day? _____
How long are your child's naps? _____
Does your child fall asleep at school? Yes_____ No _____
Does your child have a regular bedtime routine? Yes_____ No _____
If "no", do you consider this a problem? Yes _____ No _____
Does your child have his / her own bedroom? Yes _____ No _____
Is a parent present when your child falls asleep? Yes _____ No _____
If "yes", do you consider this a problem? Yes _____ No _____
What electronic devices (TV, radio, computer, IPOD, etc.) are on at bedtime?
_____
Does your child resist going to bed? Yes _____ No _____
If "yes", do you consider this a problem? Yes _____ No _____
Does your child awaken during the night? Yes _____ No _____
If "yes", do you consider this a problem? Yes _____ No _____
How many times? _____ What time of the night? _____
Does your child have difficulty falling back to sleep after a nighttime awakening?
Yes _____ No _____
If "yes", do you consider this a problem? Yes _____ No _____
How do you respond to nighttime awakenings (i.e., child is put in parents' bed, put back in their own bed, etc.)? _____
_____
Is your child difficult to awaken in the morning? Yes _____ No _____
If "yes", do you consider this a problem? Yes _____ No _____

Check the boxes that apply to your child.

Child usually falls asleep in:	**Child usually wakes in morning in:**	**Child spends most of the night in:**
Own bed alone	Own bed alone	Own bed alone
Parents' room in own bed	Parents' room in own bed	Parents' room in own bed
Parents' room in parent's bed	Parents' room in parent's bed	Parents' room in parent's bed
Sibling's room in own bed	Sibling's room in own bed	Sibling's room in own bed
Sibling's room in sibling's bed	Sibling's room in sibling's bed	Sibling's room in sibling's bed
Other location	Other location	Other location

Patient Name:_____ **DOB:**_____

Current Sleep Symptoms

Check the box that describes the frequency of your child's symptoms.

Never = Does not happen
Sometimes = 1-2 times a week
Often = 3-5 times a week
Always = 6-7 times a week

Symptom	Never	Sometimes	Often	Always
Difficulty breathing when asleep				
Stops breathing during sleep				
Snores				
Restless sleep				
Sweating during sleep				
Daytime sleepiness				
Nightmares / Night terrors				
Sleepwalking				
Sleeptalking				
Sleeps in unusual positions				
Kicks legs in sleep				
Wakes up at night				
Gets out of bed at night				
Trouble staying in own bed				
Grinds teeth				
Wets bed (over age 6)				
Discomfort in legs				
Trouble getting up in the morning				
Falls asleep in school				
Naps after school				
Feels weak or loses muscle control when laughing or upset				
Morning headaches				
Not rested after a night's sleep				
Feels like can't move upon awakening				

Parent / Legal Guardian Signature: _____ Date: _____

Physician / ARNP Signature: _____ Date: _____