UNIVERSITY of MARYLAND SHORE REGIONAL HEALTH
SLEEP DISORDERS CENTER

UM SHORE MEDICAL CENTER AT EASTON
219 S. Washington Street
Easton, MD 21601

UM SHORE MEDICAL PAVILION
125 Shoreway Drive
Queenstown, MD 21658

UM SHORE MEDICAL CENTER AT DORCHESTER
300 Byrn Street
Cambridge, MD 21613

(410) 822-1000 ext. 5338 | Fax: (410) 763-7051
www.umshoreregional.org/programs/sleep

PEDIATRIC SLEEP HISTORY

Name: _____ Age: _____ Today's date: _____

Your child's primary care physician: _____ Current weight: _____ Current height: _____

Any other physician who should received a report from this evaluation? _____

Please describe your child's main sleep problem(s): _____

_____

Duration of Problem(s): _____ Has your child been tested for sleep problems before? ❑Yes ❑No

RESPIRATORY

Does your child snore most nights? ❑Yes ❑No Does he/she snore loudly? ❑Yes ❑No
Does the snoring bother other people? ❑Yes ❑No Does position affect the snoring? ❑Yes ❑No
• For how long has the child snored? _____ *(# of years)* Has your child awoken feeling choked? ❑Yes ❑No
Has anyone seen breathing stoppages while the child slept? ❑Yes ❑No
Does he/she experience night time shortness of breath? ❑Yes ❑No

DAYTIME ALERTNESS

Is your child usually tired on awakening? ❑Yes ❑No Is he/she tired during most days? ❑Yes ❑No
Is school performance affected by sleepiness? ❑Yes ❑No Are other activities affected by sleepiness? ❑Yes ❑No

PATTERNS

Does your child maintain a regular sleep schedule? ❑Yes ❑No
What is her/his regular time for bed? _____ How long does you child typically take to fall asleep? _____
How many times does he/she wake up at night? _____
• For what reasons? _____
What is his/her usual wake up time? _____ Are weekend/days off sleep hours any different? ❑Yes ❑No
Does your child take naps? ❑Yes ❑No How many naps/day? _____
For how long? _____ minutes/hrs
Does the child feel refreshed? ❑Yes ❑No Is your child a "morning person: ❑Not at all ❑ Somewhat ❑ Very much

RESTLESS LEGS/PLM's

Does your child ever describe "creeping, crawling or uncomfortable/difficult to explain feelings in his/her legs or arms that are relieved by moving or rubbing them?

❑ Never ❑ Rarely ❑ Occasionally ❑ Frequently

If such leg/arm symptoms are occurring:

Are these feelings worsened by inactivity such as lying and sitting? ❑Not at all ❑ Somewhat ❑ Very much

Are these feelings worse in the evening and night? ❑Not at all ❑Somewhat ❑Very much

Do these feelings interfere with falling asleep or staying awake? ❑Not at all ❑Somewhat ❑Very much

Are repeated, involuntary jerking movements occurring during sleep?

❑Throughout every night ❑Frequently ❑Occasionally ❑Never or almost never

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❑Throughout every night ❑Frequently ❑Occasionally ❑Never or almost never

PARASOMNIA

Does your child: • sleep talk? ❑Yes ❑No • sleep walk? ❑Yes ❑No
• grind teeth? ❑Yes ❑No • have frequent nightmares? ❑Yes ❑No
• have frequent bedwetting? ❑Yes ❑No • physically act out dreams? ❑Yes ❑No
• eat at night without being aware? ❑Yes ❑No • experience headbanging? ❑Yes ❑No
• need to rock her/himself to sleep? ❑Yes ❑No

INSOMNIA

Does your child have difficulty with insomnia? ❑Never ❑Rarely ❑Occasionally ❑Frequently

If insomnia is a problem then please complete the questions below:

Do problems with insomnia vary with change of seasons? ❑Yes ❑No

Does he/she become frustrated/worried about the problem at night? ❑Yes ❑No

In bed, does he/she: ❑read ❑watch tv ❑play computer games ❑eat ❑clock watch ❑argue

Does your child have problems with: • anxiety? ❑Yes ❑No • depression? ❑Yes ❑No

Does he/she fall asleep more easily when not in his/her bed? ❑Yes ❑No

Have you tried any treatments for the problem?_____

PAST MEDICAL HISTORY

Has your child ever had any of the conditions listed below?

Heart or Blood pressure problems? ❑Yes ❑No When did this problem(s) begin?_____

Chronic dental problems? ❑Yes ❑No When did these problems begin?_____

Asthma? ❑Yes ❑No When did these problems begin?_____

Diabetes? ❑Yes ❑No When did these problems begin?_____

Chronic pain conditions? ❑Yes ❑No When did these problems begin?_____

Head injury/neurologic problems? ❑Yes ❑No When did these problems begin?_____

Has your child had any other serious illnesses? Approximate onset

_____ _____

_____ _____

MEDICATIONS: please list all prescription and/or over-the-counter medications taken:

_____

_____

Please list any medication allergies:_____

SLEEP HYGIENE/SOCIAL HISTORY

Is the child's bedroom comfortable for sleeping? ❑Yes ❑No Do pets interrupt the child's sleep? ❑Yes ❑No

Are there any factors in the bedroom which interfere with the child's sleep?_____

Daily caffeine intake_____ (equivalent of drinks/day)

Does your child get regular exercise? ❑every day ❑ 4-6 times/week ❑2-3 times/week ❑occasionally ❑never

Type of exercise:_____Any particular hobbies or interests?_____

REVIEW OF SYMPTOMS please check any below that are commonly experienced

❑ Anxiety attacks ❑Chronic coughs ❑Depression spells ❑Heart racing ❑Allergies ❑Sinus/Nasal problems
❑Morning headaches ❑Poor memory/concentration ❑Frequent night time urination ❑Shortness of breath
❑Passing out spells

Has the child's weight changed much in recent years? ❑Yes ❑No

If Yes, by _____ lbs. Up/down in the last ____year(s).