JOHNS HOPKINS MEDICINE
JOHNS HOPKINS ALL CHILDREN'S HOSPITAL

SLEEP MEDICINE
Patient Clinical Questionnaire

Patient Name: _____ Date of Birth: _____

What is the reason for your child's visit today and how long has your child had this problem? _____

_____

Sleep History:

	Weekdays	Weekends
What time does your child get in bed?		
What time does your child actually go to sleep?		
What time does your child wake up for the day?		
Number of night awakenings and times:		
Number of naps and times:		

Bedtime Routine:

Does your child share a room or bed? ☐ Yes ☐ No

Between going to bed and falling asleep what does your child do (e.g. TV, phone, reading, music, other)? _____

_____

What wakes your child up (e.g. hunger, using the restroom, pain, other)? _____

Number of cups of caffeine/day: _____ Number of cups of water/day: _____

Exposure to nicotine: _____

If able to drive, number of crashes or near-miss crashes associated with drowsiness or sleepiness: _____

Sleep Quality:

Rate the following 1(poor), 2(fair), or 3(good)	Parent	Child
Quality of sleep		
Level of alertness during the day		
Mood on awakening		

Check if your child experiences the following:

☐ Snoring >3 nights/week
☐ Pauses in breathing during sleep
☐ Sleep with mouth open/dry mouth
☐ Nasal congestion/allergies
☐ Sleeps with neck extended
☐ Heartburn
☐ Frequent early morning headaches
☐ Frequent kicking during sleep
☐ Abnormal feelings in the legs/feet
☐ Labored breathing at night
☐ Difficulty falling asleep
☐ Difficulty staying asleep
☐ Excessive daytime sleepiness
☐ Anxiety
☐ Depression
☐ Hyperactivity
☐ School or work problems
☐ Concentration difficulties
☐ Gasping/snorting
☐ Sleep talking
☐ Sleepwalking
☐ Sleep terrors
☐ Nightmares
☐ Acting out dreams
☐ Loss of muscle tone with emotion
☐ Inability to move upon awakening
☐ Nocturnal seizures

List any sleep medications/aids: _____

If your child uses a CPAP/BiPAP machine:

Current pressure: _____ Heated humidification? ☐ Yes ☐ No

Type of mask: ☐ Nasal pillows ☐ Nasal mask ☐ Full face mask Mask discomfort? ☐ Yes ☐ No

Number of hours of use/night: _____ Number of days of use: _____

Last month mask was replaced: _____ Last month tubing was replaced: _____

Regular cleaning of mask? ☐ Yes ☐ No DME company: _____

Nasal congestion? ☐ Yes ☐ No Other CPAP/BiPAP issues: _____

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Patient ID

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SLEEP MEDICINE
Patient Clinical Questionnaire

Patient Name: _____ Date of Birth: _____

Current medications/doses: _____

Side effects to treatment, medication allergies and reactions: _____

_____

List current medical diagnosis(es): _____

Check any symptoms present frequently or within the last week:

General:	☐ Weight gain	☐ Weight loss	☐ Fever	☐ Fatigue
Skin:	☐ Eczema	☐ Itching skin		
Abdomen:	☐ Constipation	☐ Heartburn		
Throat:	☐ Drooling	☐ Frequent tonsillitis		
Urine:	☐ Bedwetting	☐ Frequent urination	☐ Incontinence	
Eyes:	☐ Blurred vision	☐ Double vision		
Musculoskeletal:	☐ Leg cramps	☐ Muscle aches	☐ Joint pain	☐ Edema
Lungs:	☐ Cough	☐ Wheezing	☐ Difficulty breathing	
Ears/Nose:	☐ Ear infection	☐ Nasal congestion	☐ Allergies	
CNS:	☐ Headache	☐ Seizure	☐ Numbness	☐ Weakness ☐ Pain ☐ Dizziness
Psych:	☐ Anxiety	☐ Depression	☐ Hyperactivity	
Heart:	☐ Chest pain	☐ Palpitations		
Hem:	☐ Nose bleeds	☐ Easy bruising		
Endocrine:	☐ Diabetes	☐ Early sexual development		

Other: _____

If you checked any of the above, please provide additional information here: _____

_____

Family History: **Relationship to Patient:**
(please include mother, father, brother, sister, maternal/paternal grandparents)

Heart problem:	☐ Yes	☐ No	_____
OSA (obstructive sleep apnea) or snoring:	☐ Yes	☐ No	_____
Insomnia:	☐ Yes	☐ No	_____
Restless leg syndrome:	☐ Yes	☐ No	_____
Narcolepsy:	☐ Yes	☐ No	_____
Sleep talking, sleepwalking, bedwetting:	☐ Yes	☐ No	_____

Other: _____

Surgical History:

Date of tonsillectomy or adenoidectomy: _____ Additional nose/throat surgeries: _____

Other surgeries: _____

Social History:

Number of people in the home: _____ Occupation and work hours: _____

If in school, current grade level and average grades in school: _____

Due to the potential for injury or death, please do not drive or operate heavy machinery when sleepy.

Signature of Patient or Parent/Legal Guardian: _____

Printed Name of Patient or Parent/Legal Guardian: _____

Patient ID

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JOHNS HOPKINS MEDICINE
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SLEEP MEDICINE

Modified Pediatric Sleepiness Scale

Please only fill out if your child is age 6-18

Patient Name: _____ Date of Birth: _____

Rate each description according to your child's normal way of life in recent times. Even if your child has not been in some of these situations recently, try to determine how sleepy he/she would have been. Use the following scale to choose the best number for each situation:

0 = Would never doze
1 = Slight chance of dozing
2 = Moderate chance of dozing
3 = High chance of dozing

How likely is your child to doze off or fall asleep in the following situation?

Situation	Chance of dozing			
	None	Slight	Moderate	High
Sitting and reading	☐0	☐1	☐2	☐3
Watching TV	☐0	☐1	☐2	☐3
Sitting inactive in a public place (classroom, movie theater, etc.)	☐0	☐1	☐2	☐3
As a passenger in a car for an hour or more	☐0	☐1	☐2	☐3
Lying down in the afternoon	☐0	☐1	☐2	☐3
Sitting and talking to someone	☐0	☐1	☐2	☐3
Sitting quietly after lunch	☐0	☐1	☐2	☐3
Playing video games	☐0	☐1	☐2	☐3

This is the total Epworth score (add the scores up): _____

Reference: Johns, MW. A new method for measuring daytime sleepiness: the Epworth Sleepiness Scale. SLEEP. 1991;14:540-5.

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