SLEEP MEDICINE
Return Patient Clinical Questionnaire

Patient Name: _____ Date of Birth: _____

Compared to your last visit, is your child's sleep (check one): ☐ Improved ☐ Unchanged ☐ Worse

Do you have any concerns today? _____

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:		

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: _____

Current medications/doses: _____

Surgeries, hospitalizations or medical diagnoses since last visit: _____

_____

Signature of Patient or Parent/Legal Guardian: _____

Printed Name of Patient or Parent/Legal Guardian: _____

Patient ID

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Sleep Medicine >> History Form Sleep Medicine DOCIMG

JOHNS HOPKINS MEDICINE
JOHNS HOPKINS ALL CHILDREN'S HOSPITAL

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.

Patient ID

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