Pulmonary and Sleep Associates of Marin

Clinic and Pulmonary Function Lab
100 Rowland Way, Suite 300
Novato, CA 94945

Tel: 415-878-0225
Fax: 415-878-0215
www.MarinPulmonarySleep.com

Sleep Center of Marin
7100 Redwood Blvd, Suite 150
Novato, CA 94945

PEDIATRIC PATIENT MEDICAL QUESTIONNAIRE

Name:_____ **Date:**_____

Sex: M☐ **F**☐ **Age:**_____ **DOB:**_____ **Height:**_____ **Weight:**_____

Referred by Dr. _____ **Primary Care Dr.** _____

Drug Allergies? Drug Name(s):_____ Type of Reaction: _____

Parent Name(s): _____

Child's Medications:

Drug name	Dose	Times taken daily	Drug name	Dose	Times taken daily

Does your child or does anyone in the family have a medical history of the following?

Condition	Child's History	Family History	Which Relative?
Allergies			
Asthma			
Sinus problems			
Removal of tonsils/adenoids			
Seizure or Tic disorder			
High Blood Pressure			
Heart Disease			
High Cholesterol			
Diabetes			
Thyroid disease			
Acid Reflux			
Swallowing problems			

	Child's History	Family History	Which Relative?
Depression/Anxiety			
Obsessive compulsive disorder			
Attention/Hyperactivity Disorder/Autism			
Insomnia			
Sleep Apnea			
Restless Legs Syndrome			
Narcolepsy			
Abnormal Behaviors in Sleep			
Orthodontic Treatment			
Other?			

Child's Birth History and Development:

Premature birth or complications with delivery? ☐ No ☐ Yes_____

Respiratory problems or hospitalization in 1st year of life? ☐ No ☐ Yes_____

Met developmental milestones on time (sit, walk, speak)? ☐ Yes ☐ No_____

Child's Daytime Behavior/Function:

Grade Level: _____ School Performance (Average Grades): _____

Special Education Plan/Needs: ☐ No ☐ Yes_____

Problems at School (Behavior, Attention, Absenteeism): ☐ No ☐ Yes_____

Extracurricular Interests: _____

Child's Home Environment:

Describe bedroom (location, electronics, if shared) and bedtime routine: _____

_____

Caffeine Use (type, # cups/day): ☐ No ☐ Yes_____

Pets: ☐ No ☐ Yes_____

Siblings (number, ages): ☐ No ☐ Yes _____

Please describe the nature of your child's primary problem that you would like to discuss:

_____

_____

Please complete the following regarding your child's sleep:

How long has there been a sleep problem (months, years)? _____

What time is bedtime? _____ How long does it take to fall asleep? _____

How many awakenings on average during the night? _____ How much time is spent awake? _____

What time does your child get out of bed in the morning? _____

Please mark No or Yes to the following:

	No	Yes
Does your child snore?	☐	☐
Has someone witnessed your child stop breathing when asleep?	☐	☐
Does your child wake up gasping or choking or with shortness of breath?	☐	☐
Does your child breath with his/her mouth open and/or complain of a dry mouth?	☐	☐
Does your child grind, clench his/her teeth at night or complain of a sore jaw in the A.M.?	☐	☐
Does your child have night sweats?	☐	☐
Does your child wake up at night with heartburn/acid reflux or cough? _____	☐	☐
Is your child a restless sleeper (moves a lot in bed or has fallen out of bed)? _____	☐	☐
Does your child have bedwetting? If yes, since when? _____	☐	☐
Does your child wake up with a headache? If yes, describe: _____	☐	☐
Does your child have trouble falling or staying asleep? _____	☐	☐
If yes, do they take a sleep aid? Which one? _____	☐	☐
At bedtime, is there worry, anxiety, or resistance to going to sleep?	☐	☐
Does your child stay in his or her bed at night?	☐	☐
Does your child wake up without an alarm?	☐	☐
Is it difficult to get your child out of bed due to sleepiness?	☐	☐
Is your child's sleep unrefreshing?	☐	☐
Does your child feel sleepy or drowsy during the day or fall asleep during class?	☐	☐
Does your child feel fatigued, tired, or have low energy during the day?	☐	☐
Does your child take naps? How many naps and for how long? _____	☐	☐
Does your child find naps to be unrefreshing?	☐	☐
Does your child have problems with focus, paying attention, or organization?	☐	☐
If yes, has the teacher or daytime caregiver mentioned this to you?	☐	☐
Does your child have problems with anxiety, depression or irritability?	☐	☐
Does your child have problems with hyperactivity?	☐	☐
Does your child have night leg complaints? (restless or sore legs, urge to move legs)	☐	☐
Does your child kick his/her legs excessively while asleep?	☐	☐
Does your child have any history of sleepwalking, sleep talking, groaning, sleep eating,	☐	☐
dream enactment or other behaviors in sleep? _____	☐	☐
Does your child wake up screaming, confused or violent?	☐	☐
Does your child have frequent nightmares?	☐	☐
Does your child experience hallucinations while falling or upon awakening?	☐	☐
Does your child ever experience paralysis when falling asleep or waking up?	☐	☐
Has your child ever experienced muscle weakness associated with extreme emotions, such	☐	☐
as laughter, anger, or surprise that causes knee buckling, jaw slackness, or collapse?	☐	☐
Does your child's sleep problem interfere with daily functioning? _____	☐	☐
Are you concerned about the long-term consequences of your child's sleep problem?	☐	☐