Pulmonary and Sleep Associates of Marin

Phone: 415-878-0225
100 Rowland Way, Suite 300
Fax: 415-878-0215
Novato, CA 94945
MarinPulmonarySleep.com

PEDIATRIC PATIENT MEDICAL QUESTIONNAIRE

Name:____ **Date:**______________

Sex: M___ F___ Age:_____ DOB:___________ Height:______ Weight:______

Referred by Dr. ____________________ **Primary Care Dr.** ___________________

Reason for Consultation: ____

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

Child's Past Medical and Surgical History:

Date of diagnosis	Diagnosis, Medical Problem, Surgery, or Hospitalization

In the past 2 weeks, has your child had any of the following symptoms (Circle if applies):

Weight Change	Fevers/Chills	Rash/Skin Changes	Headache
Vision Changes	Hearing Loss/Ringing	Sinus Pain	Nasal Congestion
Sore Throat	Difficulty Swallowing	Cough	Shortness of Breath
Chest Pain	Palpitations	Heartburn	Nausea/Vomiting
Constipation	Diarrhea	Urinary Problems	Joint/Muscle Pain
Swelling	Weakness	Numbness/Tingling	Tremor
Dizziness	Confusion	Incoordination/Falls	Anxiety/Depression

Additional Medical History:

Does your child or does anyone in the family have a history of the following? (Check boxes)

Condition	**Child's History**	**Family History**	**Which Relative?**
Allergies			
Asthma			
Cancer			
High Blood Pressure			
Heart Disease/Heart Failure			
High Cholesterol			
Heart Attack			
Stroke			
Diabetes			
Hypothyroidism			
Heartburn/Reflux			
Depression/Anxiety			
Attention/Hyperactivity Disorder (ADD/ADHD)			
Insomnia			
Sleep Apnea			
Restless Legs Syndrome			
Narcolepsy			
Abnormal Behaviors in Sleep			
Orthodontic Treatment			
Other not detailed above? Please specify:			

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 _____________________________

Exposures (Circle if applies): Tobacco, Lead, Asbestos, Fumes, Chemicals, Molds, Other______

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? ___<1 mo ___1-3 mo ___3-6 mo ___ 6-11 mo ___ year(s)
What time is bedtime? _______________ How long does it take to fall asleep? _______________
What happens if cannot 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? _______________

	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 have a dry mouth at night or in the morning upon awakening?		
Does your child grind or clench his or her teeth at night?		
Does your child have night sweats?		
Does your child have heartburn, reflux, chest pain, palpitations, or body pain at night?		
Does your child have bedwetting or get up during the night to urinate?		
Does your child wake up with a headache in the morning? Describe the headache:____		
Is your child a restless sleeper?		
Does your child have trouble falling or staying asleep?		
If your child wakes up at night, is it hard to fall back asleep?		
Does your child need sleep aids to fall asleep or stay asleep? Which? ________________		
At bedtime, is there worry, anxiety, or resistance to going to sleep?		
Does your child have a regular sleep schedule?		
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?		
Does your child have problems with anxiety, depression, or irritability?		
Does your child have problems with hyperactivity?		
Does your child have growing pains or restless legs (crawling, aching, or inability to stay still)? How severe is it? Medication use? ____		
Does your child kick his or her legs at night or move excessively while asleep?		
Does your child have any history of sleepwalking, sleep talking, groaning, sleep eating, dream enactment such as hitting or kicking, rocking, or other behaviors in sleep?		
Does your child wake up screaming, confused, or violent?		
Does your child have frequent nightmares?		

	No	Yes
Does your child experience hallucinations while falling asleep 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 (i.e., 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?		

What is the average bedtime and wake time on weekends or vacation? BT__________ WT__________
What is your child's preferred sleep timing? ___ Night Owl ___ Morning Lark ___ Neither/Mixed

EPWORTH SLEEPINESS SCALE:
This scale helps us determine how likely your child is to doze off in the following situations. It refers to your child's usual way of life in recent times. Use the following scale to **choose the most appropriate number** for each situation.

0=no chance of dozing
1=slight chance of dozing
2=moderate chance of dozing
3=high chance of dozing

SITUATION	0-3
Sitting and reading	
Watching TV	
Sitting inactive in a public place (i.e., theater or meeting)	
As a passenger in a car for an hour without a break	
Lying down to rest in the afternoon	
Sitting and talking to someone	
Sitting quietly after a lunch without alcohol	
In a car, while stopped for a few minutes in traffic	