Patient Name _____ Date of Birth _____ Today's Date _____

Houston Pediatric Pulmonary and Sleep Associates
New Patient Questionnaire - Sleep

Birth History

What hospital/birth center? _____

C-section or vaginal delivery? ◯ c-section ◯ vaginal

What was the birth weight? _____

What was the baby's gestational age at birth? _____

How long was the baby in the hospital? _____

Please list any problems/complications:

Past Medical History

Please list the patient's current medical problems: ☐ None

Please list all surgeries in the patient's lifetime: ☐ None

Surgery:	Date:	Surgeon:

Please list the patient's current medications (if additional room is needed, please provide attached list): ☐ None

Name: ☐ See attached.	Frequency/Dose/Strength:

Please list any allergies (medication, food, other): ☐ None

What is the name of your current home health care company?

_____

Family History

Please list the patient's siblings: ☐ None

Name:	Birth Date:	Gender:
		◯ M ◯ F
		◯ M ◯ F
		◯ M ◯ F
		◯ M ◯ F
		◯ M ◯ F

Are there any medical problems in the family? Be sure to include any breathing, sleeping or psychiatric problems.

Family Member	Disease/Problem ☐ None

Social History

Does patient attend any type of daycare? ☐ Yes ☐ No

Does anyone the patient knows smoke? ☐ Yes ☐ No

Please list any pets in the home: ☐ None

Do any of the pets sleep with the patient? ☐ Yes ☐ No

Does the patient share a bedroom with anyone? ☐ Yes ☐ No

Does the patient share the bed with anyone? ☐ Yes ☐ No

Sleep History

Please answer for both, **S**chool **N**ights (**SN**) and **Wee**k**e**nds (**WE**), for each question.	**SN:**	**WE:**
What time does the patient go to bed?		
How long does it take for the patient to fall asleep?		
At what time does the patient wake up to start their day?		
How many times does the patient wake up throughout the night?		
How many naps does the patient take during the day?		
How long is each nap?		

Patient Name _____ Date of Birth _____ Today's Date _____

Review of Systems

Constitutional

Fever (recent, or recurrent)	☐ Yes	☐ No
Night sweats	☐ Yes	☐ No
Weight ◯ loss or ◯ gain	☐ Yes	☐ No
Decreased energy	☐ Yes	☐ No
Appetite changes	☐ Yes	☐ No
Difficulty gaining weight	☐ Yes	☐ No

Eye

Itchy eyes	☐ Yes	☐ No
Watery eyes	☐ Yes	☐ No
Red eyes	☐ Yes	☐ No
Vision Problems	☐ Yes	☐ No

Ear, Nose, Mouth, & Throat

Runny nose	☐ Yes	☐ No
Nasal congestion	☐ Yes	☐ No
Frequent sinus infections	☐ Yes	☐ No
Frequent sniffing or sneezing	☐ Yes	☐ No
Frequent throat clearing	☐ Yes	☐ No

Cardiovascular

Heart murmur or heart problem	☐ Yes	☐ No
Chest pain	☐ Yes	☐ No
Exercise limitation	☐ Yes	☐ No
Fainting Spells	☐ Yes	☐ No

Gastrointestinal

Vomiting or excessive spit up	☐ Yes	☐ No
Constipation	☐ Yes	☐ No
Heart burn	☐ Yes	☐ No
Frequent abdominal pain	☐ Yes	☐ No
Frequent burping	☐ Yes	☐ No
Frequent hiccups	☐ Yes	☐ No
History of iron or other nutritional deficiency	☐ Yes	☐ No

Endocrine

Too hot or too cold	☐ Yes	☐ No
Blood sugar problems (including diabetes)	☐ Yes	☐ No
Easy bruising	☐ Yes	☐ No
Take birth control pills	☐ Yes	☐ No

Other

Please note any other important symptoms not listed above:

Neurological

Frequent headaches	☐ Yes	☐ No
Convulsions or seizures	☐ Yes	☐ No
Developmental delays	☐ Yes	☐ No
Is or was your child enrolled in ECI?	☐ Yes	☐ No
Does your child require special classes in school?	☐ Yes	☐ No
Does your child require therapy?	☐ Yes	☐ No

If yes, please identify
◯ Speech ◯ Language ◯ Physical ◯ Occupational

Sleep - Daytime

Hyperactive	☐ Yes	☐ No
Difficulty focusing/concentrating	☐ Yes	☐ No
Irritability	☐ Yes	☐ No
Defiant	☐ Yes	☐ No
Dry mouth in the morning	☐ Yes	☐ No
Too sleepy during the day	☐ Yes	☐ No
Falls asleep at inappropriate times	☐ Yes	☐ No

Sleep - Nighttime

Snores more than 3 nights per week	☐ Yes	☐ No
Episodes where patient stops breathing while sleeping	☐ Yes	☐ No
Chokes/gags/gasps/snorts while sleeping	☐ Yes	☐ No
Kicks legs while asleep	☐ Yes	☐ No
Body movements while asleep	☐ Yes	☐ No
Sleep walking	☐ Yes	☐ No
Sleep talking	☐ Yes	☐ No
Has difficulty falling asleep	☐ Yes	☐ No
Teeth grinding	☐ Yes	☐ No
Bed wetting	☐ Yes	☐ No

Psychiatric

Symptoms of anxiety (excessive worries)	☐ Yes	☐ No
Symptoms of depression (hopeless, helpless, excessive sadness, crying)	☐ Yes	☐ No
Behavioral problems (fighting at school)	☐ Yes	☐ No
Other psychiatric conditions	☐ Yes	☐ No

Allergic/Immunologic

Eczema (dry, rough, or itchy skin)	☐ Yes	☐ No
Hives (urticaria)	☐ Yes	☐ No
Allergies (allergic rhinitis, hay fever, etc.)	☐ Yes	☐ No