

Developmental History

Does the child have a history of developmental delay or birth defects?

If yes, please describe:

Past Medical History (answer 'Y' or 'N' where applicable)

Has the child had a sleep study or apnea monitor in the past? When?

List all hospitalizations your child has had (Include month/year)

- 1.
- 2.
- 3.

List all surgeries your child has had (Include month/year)

- 1.
- 2.
- 3.

Other significant medical problems for which you have seen a doctor

- 1.
- 2.
- 3.

Medication History (include prescription & over the counter)

List all current medications Dosage # of times a day Mo/Yr started

- 1.
- 2.
- 3.

List any sleep medications taken (currently and in the past)

- 1.
- 2.
- 3.

Allergies

List all medication allergies:

- 1.
- 2.
- 3.

List all environmental allergies (food, plants/mold, animals, other substances):

- 1.
- 2.
- 3.

Social History (answer 'Y' or 'N' where applicable)

Are biological parents together? If not, who has custody?

Are there smokers in the home?

Does the child drink alcohol? Caffeine (coffee, soda, chocolate)?

What school grade is the child in? Learning disability/Special Ed?

Do you have any pets?

Do you have a unique diet (for example, vegetarian or no meat)?

How long has the family lived in Alaska?

Sleep History (see also Sleep Log in your packet)

Usual Weekday Sleep Hours:

12	1	2	3	4	5	6	7	8	9	10	11	12	1	2	3	4	5	6	7	8	9	10	11
pm												am											

Usual Weekend Sleep Hours:

12	1	2	3	4	5	6	7	8	9	10	11	12	1	2	3	4	5	6	7	8	9	10	11
pm												am											

X = Time child usually goes to bed
 XX = Time child usually falls asleep
 O = Usual naptimes during the day

W = Usual nighttime wakeups/arousals
 WW = Time child usually wakes up

Example:

	O							X		XX				W		W					WW			
12	1	2	3	4	5	6	7	8	9	10	11	12	1	2	3	4	5	6	7	8	9	10	11	
pm												am												

Nighttime Symptoms (answer 'Y' or 'N' where applicable)

Does the child snore?	Since when?
Does the child stop breathing at night?	
Is the child a restless sleeper?	
Does the child move legs and/or arms frequently at night?	
Does the child move legs and/or arms frequently before falling asleep?	
Does your child have night sweats?	
Wet the bed?	Since when?
	How often?
Talk during sleep?	Sleepwalk?
	How often?
Grind teeth during sleep?	
Acid reflux/heartburn at night?	How often?
Have bad nightmares when waking up or falling asleep?	
Other nighttime problems:	

Daytime Symptoms (answer 'Y' or 'N' where applicable)

Is the child sleepy during the day?
Is the child hyperactive or inattentive compared with other kids?
Does the child have stuffy nose or breathe with mouth open during the day?
Does the child have dry mouth in the morning?
Does the child have headaches in the morning?
Other daytime problems:

Other Information you would like us to know: