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JERALD H. SIMMONS, MD

CSMA Pediatric Sleep Questionnaire

Name: _____ **Age:** ____ **Ht:** ___ft___in **Wt:** ___lbs **Date:** _____

Birth Date _____ **Gender** M F **Parents Name** _____

Parents Phone Number(s) Hm _____ **Wk** _____ **Cell** _____

1. What time does your child typically go to bed? _____ If not a routine time, then state the range: _____
2. Does your child have difficulty *falling* asleep at the beginning of the night?..... Yes No
3. Does your child have difficulty *staying* asleep throughout the night? Yes No
If yes, typically how many awakenings? _____ and average time to fall back asleep? _____
4. What time does your child typically wake up to start their day? _____ Is it difficult to wake them up? Yes No
5. Does your child experience cramps or pains in their legs or feet while lying in bed in the evening or at night? Yes No
If yes, how often? ___Rarely (25%) ___Half the time (50%) ___Most of the time (75% or more)
6. Does your child kick or twitch their legs while they are asleep? Yes No
7. Does your child *snore* at night? Yes No
If yes, how would you rate the severity? **Mild Moderate Severe**
8. Does your child have *pauses* in breathing or *gasp*ing sounds during sleep?..... Yes No
If yes, how frequent are the pauses or gasping? ___Throughout the night ___Frequently ___Occasionally
9. Does your child have unusual behaviors during sleep (sleep walking, talking ..etc)?..... Yes No
If yes, how often? _____ and briefly describe what your child does in their sleep: _____
If yes, what part of the night do these activities typically occur? ___First 90 minutes ___First 3 hrs ___Last 3 hrs of sleep?
10. Check those that apply to your child: Does your child frequently wake up with:
 ___a dry mouth ___headaches ___excessive sweating ___heart burn ___chest pain ___aching in jaws or TMJ pain ___choking or gasping
 ___drooling on the pillow ___ bed wetting (loss of bladder control) ___ leg cramps ___ nightmares
 ___nasal congestion on awakening (which was not present when you went to bed)
11. Does your child have: (check those that apply to your child)
 ___ difficulty maintaining concentration during the day? If yes, have they been diagnosed with ADD? Yes No
 ___ hyperactive behaviors during the day (has difficulty sitting still)? If yes, have they been diagnosed with ADHD .Yes No
13. Does your child have problem being *sleepy* during the day?... Yes No, If yes, does your child take naps frequently? Yes No
If yes, how often? _____ and typically how long is each nap? _____
- 14) Use the following scales to circle the number that best describes the likelihood, over the last month, of feeling drowsy or dozing off during the day under each of the situations listed below. **0 = never, 1= rarely 2 = more than rarely but not all the time, 3= Every time**

Sitting and reading	0	1	2	3
Sitting and watching Tv	0	1	2	3
Sitting in a class at school during the morning	0	1	2	3
Sitting and riding in a car or a bus for about half an hour	0	1	2	3
Lying down to rest or nap in the afternoon	0	1	2	3
Sitting and talking to someone	0	1	2	3
Sitting quietly by yourself after lunch	0	1	2	3
Sitting and eating a meal	0	1	2	3

-----USE A SEPARATE SHEET OF PAPER IF NEEDED TO ANSWER THE QUESTIONS BELOW -----

Please describe your child's sleep problems:

List other medical problems your child has:

List medications your child is taking:

Have they had a sleep study before? Yes / No

When and Where? _____ Can you get the report? Yes / No

Who filled out this questionnaire? _____

Referring Physician _____
Physician Phone Number _____
Insurance _____