Stony Brook Medicine

Stony Brook University Hospital
Sleep Disorders Center
240 Middle Country Road, Suite A
Smithtown, NY 11787

TEL: 631.444.2500
FAX: 631.444.2580

Why is your child being seen in the sleep clinic?

_____

_____

_____

Has your child had a sleep evaluation in the past? (if yes, when/where and which CPAP machine did you receive?)

_____

_____

SLEEP HABITS

WHILE FALLING ASLEEP:
What time do you usually go to bed on weekdays/school-days? _ : _ am/pm
How long does it take you to fall asleep? ____ minutes

What time do you usually go to bed on weekends/days off? _ : _ am/pm
How long does it take you to fall asleep? ____ minutes

As you are falling sleep, do you experience:
- Restless leg syndrome (*Urge to move your legs, or a crawling, creeping, pulling, or itching sensation relieved by moving your legs)*
- Visual, tactile, or auditory hallucinations
- Often experiencing an inability to relax
- Intense thoughts

WHILE ASLEEP, DO YOU…:

• Snores heavily.	If yes, how many times per week: ___
• Stop breathing.	If yes, how many times per week: ___
• Awaken choking or gasping.	If yes, how many times per week: ___
• Teeth grinding.	If yes, how many times per week: ___
• Act out your dreams.	If yes, how many times per week: ___
• Have nightmares.	If yes, how many times per week: ___
• Sleep walk.	If yes, how many times per week: ___
• Sleep talk.	If yes, how many times per week: ___

How many times do you wake up in a typical night? ___
How long does it usually takes you to fall back to sleep? ___ minutes.

WAKING UP:
What time do you usually awaken on weekdays/workdays? __: __ am/pm
- To an alarm clock • Spontaneously

How many hours do you sleep per weeknight/worknight? ___ hours.
How many hours do you spend in bed per weeknight? ___ hours.
Is it refreshing: • Never/Rarely • Sometimes • Often/Always

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What time do you usually awaken on weekends/days off? _ : _ am/pm
• To an alarm clock • Spontaneously
How many hours do you sleep on those nights? ___ hours.
How many hours do you spend in bed on those nights? ___ hours.
Is it refreshing: • Never/Rarely • Sometimes • Often/Always

Upon awakening, do you experience:
- Congested nose
- Dry mouth
- Sore throat
- Morning headache
- Bed in disarray
- Paralysis
- Hallucinations
- Sudden extreme muscle weakness (cataplexy)

DURING THE DAY:
How many naps do you take daily? ___
How many minutes is each nap? ___
Do you feel refreshed after the nap(s)? • Yes • Sometimes • No

Are you sleepy while driving? • Yes • Sometimes • No
Are you honked at red lights? • Yes • Sometimes • No
Have you had a motor vehicle accident related to sleepiness? • Yes • No
Do you have narcolepsy (overwhelming daytime drowsiness & sudden attacks of sleep) • Yes • No
Do you have cataplexy (sudden loss of muscle tone) • Yes • No

Do you have the following (central sensitization syndromes) somatic symptom disorders?
- Chronic Fatigue Syndrome
- Chronic migraine or tension-type headaches
- Temporomandibular joint (TMJ) syndrome
- Fibromyalgia
- Joint hypermobility Syndrome
- Mitral valve prolapse syndrome
- Irritable Bowel Syndrome (IBS)

REVIEW OF SYSTEMS Check all boxes that apply to you:

GENERAL	ENDOCRINE	GASTROINTESTINAL

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• Fever or chills	• Heat/cold intolerance	• Heartburn
• Loss of appetite	• Excessive thirst	• Nausea or vomiting
EYES	BLOOD	• Constipation
• Visual changes	• Anemia	• Diarrhea
• Eye dryness/ tearing	• Easy bruising/bleeding	• Abdominal pain
EARS/NOSE/THROAT	URINARY	• Abdominal bloating
• Hearing loss	• Urinate frequently	NEUROLOGICAL
• Bad breath	• Urinary incontinence	• Headaches
CARDIOVASCULAR	MUSKULOSKELETAL	• Tremors
• Chest pain	• Joint pain	• Numbness/Tingling
• Palpitations	• Muscle pain	• Seizures
• Swelling of feet	• Cramps	• Dizziness/Fainting
RESPIRATORY	SKIN	PSYCHIATRIC
• Shortness of breath	• Rashes	• Anxiety/Nervousness
• Cough	• Dryness	• Depression
• Wheezing		• Memory Loss

PAST MEDICAL HISTORY Do you have any of the following medical conditions?

- Seasonal Allergies
- Rhinitis/sinusitis
- Cardiac arrhythmia
- Gastroesophageal reflux
- Learning disabilities
- Asthma
- Diabetes
- Anemia
- Attention deficit disorder
- Autism
- Tonsillar Hypertrophy
- Seizures
- Thyroid disease
- Migraine/tension headaches

Other: _____

SURGICAL HISTORY

Have you had a tonsillectomy: • Yes • No

Have you had any complications related to anesthesia? • Yes • No

List all other surgical procedures that you have had: _____

_____

MEDICATIONS (Please list all the medications that you currently take.)

Medication name	Dose	Times per day	Medication name	Dose	Times per day
1.			6.		
2.			7.		

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3.			8.		
4.			9.		
5.			10.		

ALLERGIES Are you allergic to any medication? • Yes • No
If yes, please list the medication and your reaction to it.

Medication name	Reaction	Medication name	Reaction

SOCIAL HISTORY

Lives with: ____
School grade: ____
Do teachers complain of classroom naps: [ ]YES [ ]NO

FAMILY HISTORY Does anyone in your immediate family have the following medical conditions?

	Father	Mother	Brother/Sister	Children
High blood pressure				
Heart attacks				
Asthma				
COPD/Emphysema				
Diabetes				
Depression				
Obesity				
Snoring				
Sleep apnea				
Narcolepsy				
Thyroid gland disease				
ADHD				
Parkinson's Disease				
Dementia				
Strokes				

PARENT QUESTIONNAIRE

For Kids Sleepiness Scale (KISS)

How sleepy is your child in the following situations? Consider how your child was the past week or so. Circle your answer choice.

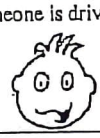
CHANCE OF FALLING ASLEEP:	0  NO CHANCE	1  LITTLE	2  MORE	3  A LOT

1. Doing homework	0	1	2	3
2. Watching TV	0	1	2	3
3. Sitting in the classroom while listening to your teacher	0	1	2	3
4. Riding in the backseat of a car while someone is driving	0	1	2	3
5. Resting at home in the afternoon, after school	0	1	2	3
6. Playing with friends	0	1	2	3
7. Sitting in the classroom after lunch	0	1	2	3
8. Waiting for the bus at the bus stop	0	1	2	3

CHILD QUESTIONNAIRE

Kids Sleepiness Scale (KISS)

How sleepy are you in the following situations? Consider how you have felt in the past week or so. Circle your answer choice.

CHANCE OF FALLING ASLEEP:	 NO CHANCE	 LITTLE	 MORE	 A LOT
1. Doing homework				
2. Watching TV				
3. Sitting in the classroom while listening to your teacher				
4. Riding in the backseat of a car while someone is driving				
5. Resting at home in the afternoon, after school				
6. Playing with friends				
7. Sitting in the classroom after lunch				
8. Waiting for the bus at the bus stop