PennState Health
Milton S. Hershey
Medical Center

Today's Date: __________

ADOLESCENT SLEEP HABITS SURVEY (PARENT VERSION)

ADOLESCENT SLEEP HABITS SURVEY (PARENT VERSION)

1. Name of Patient: ______________________ 2. Date of Birth:___/___/___
3. Name of person completing questionnaire ______________________
   Relationship to child ______________________
   Referred by ______________________
   Pediatrician ______________________
4. A copy of the sleep clinic evaluation will be sent to you, your pediatrician, and any referring physician. Please indicate anyone else who should receive a copy:
   Name: ______________________ Address: ______________________
   ____
5. What are your major concerns about your adolescent's sleep? ______________________
   ____
   ____
6. What do you think is causing your adolescent's sleep problem? ______________________
   ____
7. When did your adolescent's sleep problems start? ______________________
   ____

FAMILY INFORMATION

8. Please list all members of the households in which your adolescent lives full or part-time:

Name/Relationship to Adolescent	Age	Adolescent lives with (please indicate full-time or part-time)

9. Mother's Marital Status: Married Divorced Separated Widowed Single
   If divorced, adolescent custody with: ______________________
10. Mother's education: ______________________
11. Mother's occupation: ______________________
   Does mother work outside of home? ☐ yes ☐ no
   If yes, mark each label that best describes her work:
   - ☐ day shift
   - ☐ evening shift
   - ☐ night shift (graveyard)
   - ☐ changing shifts
   - ☐ full time
   - ☐ part time
   - ☐ one job
   - ☐ more than one job

12. Father's Marital Status: Married Divorced Separated Widowed Single

If divorced, adolescent custody with: ______________

13. What is father's education: ______________

14. Father's occupation: ______________

Does father work outside of home? ☐ Yes ☐ No

If yes, mark each label that best describes his work:

☐ day shift	☐ full time
☐ evening shift	☐ part time
☐ night shift (graveyard)	☐ one job
☐ changing shifts	☐ more than one job

15. What best describes your adolescent's racial/ethnic background?

White/Caucasian ______	Asian/Asian American ______
Black/African American ______	Native American ______
Hispanic/Latino ______	Multiracial (Please specify) ______

Other (Please specify) ______________

16. Please list family members (parents, grandparents, siblings, aunts/uncles) with a history of any SLEEP PROBLEMS (including: loud snoring/obstructive sleep apnea, excessive sleepiness/ narcolepsy, restless legs/periodic leg movements, insomnia, other sleep problems).

Family Member	Type of Sleep Problem

17. Has anyone in your family ever had a car accident caused by sleepiness (not due to alcohol or drugs)? Yes ☐ No ☐ Don't know ☐

If yes, whom: ______________ At what age: ______________

Type of accident: ______________

18. Please list any family members with a significant mental health condition (such as depression, anxiety, alcoholism/substance abuse).

Family Member	Type of Mental Health Problem

SLEEP HISTORY (GENERAL)

19. What time does your adolescent <u>usually</u> go to bed on school nights? __________
Range: _____ am/pm to _____am/pm

20. What is the main reason your adolescent goes to bed at a particular time? (Check <u>one</u> below)

_____ a. Because it fits best with the family's schedule
_____ b. Because she/he feels sleepy then
_____ c. Because that is when her/his TV shows are over
_____ d. Because that is when her/his brothers and sisters go to bed
_____ e. To "get enough sleep" for the following day's activities
_____ f. Other (describe briefly)____

21. What time does your adolescent <u>usually</u> wake up on school day mornings? ___________
Range: _____ am/pm to _____am/pm

22. What usually wakes up your adolescent in the morning on school days? (Check <u>one</u> below)

_____ a. Alarm clock
_____ b. Parent or other family member
_____ c. Noise
_____ d. Needs to go to the bathroom
_____ e. Spontaneous
_____ f. Other (<u>describe briefly</u>):

23. Which of the following applies to waking your adolescent in the morning on school days? (Check <u>one</u> below)
_____ a. I almost always have great difficulty getting him/her out of bed
_____ b. I sometimes have great difficulty getting him/her our of bed
_____ c. I seldom have great difficulty getting him/her out of bed
_____ d. I never have great difficulty getting him/her out of bed

24. What times does your adolescent <u>usually</u> go to bed on weekend nights? ____________
Range: _____ am/pm to_____am/pm

25. What time does your adolescent <u>usually</u> wake up on weekend mornings? ___________
Range: _____ am/pm to _____am/pm

26. What usually wakes up your adolescent in the morning on weekends? (Check <u>one</u> below)

_____ a. Alarm clock
_____ b. Parent or other family member
_____ c. Noise
_____ d. Needs to go to the bathroom
_____ e. Spontaneous
_____ f. Other (<u>describe briefly</u>):

27. Which of the following applies to waking your adolescent in the morning on weekends? (Check <u>one</u> below)
_____ a. I almost always have great difficulty getting him/her out of bed
_____ b. I sometimes have great difficulty getting him/her our of bed
_____ c. I seldom have great difficulty getting him/her out of bed
_____ d. I never have great difficulty getting him/her out of bed

28. IN AN AVERAGE TWO-WEEK PERIOD, HOW OFTEN DOES YOUR ADOLESCENT ..

(Check one answer for each question; please feel free to comment)

	Every day/ night	5-6 times	3-4 times	1-2 times	Never	Comments:
snore?	☐	☐	☐	☐	☐	____
snore loudly and disruptively?	☐	☐	☐	☐	☐	____
sleep restlessly?	☐	☐	☐	☐	☐	____
sleep in an abnormal position?	☐	☐	☐	☐	☐	____
sweat while sleeping?	☐	☐	☐	☐	☐	____
pause in breathing	☐	☐	☐	☐	☐	____
complain of headache on waking?	☐	☐	☐	☐	☐	____
have nightmares?	☐	☐	☐	☐	☐	____
sleepwalk?	☐	☐	☐	☐	☐	____
sleeptalk?	☐	☐	☐	☐	☐	____
cry out during sleep?	☐	☐	☐	☐	☐	____
wake up at night?	☐	☐	☐	☐	☐	____
get out of bed at night?	☐	☐	☐	☐	☐	____
complain about his/her sleep?	☐	☐	☐	☐	☐	____
complain of pain at night?	☐	☐	☐	☐	☐	____
wet the bed?	☐	☐	☐	☐	☐	____

29. Has your adolescent ever used medication (over-the-counter or prescription) including herbal or "natural" remedies to help with sleep?

Yes ☐ No ☐ Don't know ☐

If yes, name of medication and how frequently used: ____________________

30. Does your adolescent currently (within the past month) use medications (over-the-counter or prescription) to help with sleep? Yes ☐ No ☐ Don't know ☐

If yes, name of medication and how frequently used: ____________________

SLEEP HISTORY - DAYTIME SLEEPINESS

31. During the LAST TWO WEEKS, has your adolescent struggled to stay awake (fought sleep) or fallen asleep in the following situations? (Mark one answer for every item)

	No	Struggled to stay awake (fought sleep)	Fallen asleep	Don't Know	Does not Apply
a. in a face-to-face conversation with another person?	☐	☐	☐	☐	☐
b. traveling in a car, bus?	☐	☐	☐	☐	☐
c. at the movies?	☐	☐	☐	☐	☐
d. watching television?	☐	☐	☐	☐	☐
e. listening to the radio or stereo?	☐	☐	☐	☐	☐
f. reading, studying or doing homework?	☐	☐	☐	☐	☐
g. in a class at school?	☐	☐	☐	☐	☐
h. while doing work on a computer or typewriter?	☐	☐	☐	☐	☐
i. playing video games?	☐	☐	☐	☐	☐
j. eating a meal?	☐	☐	☐	☐	☐

MEDICAL HISTORY:

32. Were there any problems with this pregnancy or delivery (prematurity, high blood pressure, etc.)? ____

____

33. What was the birth weight? ____________

34. Was your adolescent ever on an apnea monitor at home? Yes ☐ No ☐

If yes, for how long? _________

35. Does your adolescent have any significant health problems? Yes ☐ ______ No ☐

If so, please describe: ____

____

36. Has your adolescent ever been hospitalized? Yes ☐ No ☐

If yes, when: ______________________ What for? ______________________________

______________________ ______________________________

______________________ ______________________________

37. Has your adolescent ever had any operations (other than tonsils/adenoids removal)?

Yes ☐ No ☐

If yes, type of operation? ____________________________ Year ________________

____________________________ Year ________________

____________________________ Year ________________

38. Have your adolescent's tonsils or adenoids been removed?

a. Tonsils: Yes ☐ At what age?_______

For what reason: ______________________________

b. Adenoids: Yes ☐ At what age?_______

For what reason: ______________________________

c. Describe briefly any changes you noticed in your adolescent's sleep or waking behavior after removal of tonsils or adenoids: ______________________________

39. If NO, do you think the tonsils or adenoids are a problem? Yes ☐ No ☐ Don't know ☐
For how long have they been a problem? _______ years

40. Has your adolescent ever broken his/her nose or other facial bones? Yes ☐ No ☐

41. Does your adolescent have difficulty breathing through his/her nose? Yes ☐ No ☐

42. In the past year, has your adolescent had strep throats/tonsillitis?________________

Yes ☐ No ☐

Frequent colds/respiratory infections? Yes ☐ No ☐

Frequent sinus infections? Yes ☐ No ☐

43. Does your adolescent have allergies? Yes ☐ No ☐ Possibly ☐
If yes, to what?______________________________

44. Does your adolescent have asthma? Yes ☐ No ☐ If "Yes", please answer the following questions:

In the **past year**....
a. How many days has your adolescent missed school due to asthma? _______ None ☐
b. How many days has your adolescent been hospitalized for asthma? _______ None ☐
c. List any medications your adolescent takes for asthma:

Type: ____________________ Frequency: ____________________
Type: ____________________ Frequency: ____________________
Type: ____________________ Frequency: ____________________

45. Does your adolescent frequently complain of heartburn? Yes ☐ No ☐ Don't know ☐

Has he/she ever been diagnosed with gastroesophageal (stomach) reflux?

Yes ☐ No ☐ Only when younger ☐

46. Has your adolescent had any head injuries requiring medical evaluation and/or treatment or loss of consciousness? If yes, please describe:______________________________

47. List any prescription or over-the counter medications your adolescent has taken in the last month:

Type: ____________________ Reason for medication: ____________________

Type: ____________________ Reason for medication: ____________________

Type: ____________________ Reason for medication: ____________________

48. Menstrual history (Girls only):
   a. Age she started menstruating ________ years
   b. Regularity of her menstrual periods:
      - ☐ About one per month (28 days)
      - ☐ Usually much longer than one month between periods
      - ☐ Usually shorter than one month between periods
      - ☐ Very irregular; no apparent pattern
      - ☐ Do not know
   c. Number of days since her last menstrual period ________

49. Do you have additional comments about your adolescent's medical history? (Continue on additional sheets if necessary.)

____

____

____

HEALTH HABITS - Please answer the following questions regarding health habits which may impact on sleep.

50. In the past month, how much did your adolescent use tobacco products?

- ☐ More than one pack (20 cigarettes) per day
- ☐ Between 5 and 20 cigarettes per day
- ☐ Between 1 and 5 cigarettes per day
- ☐ Less than 1 cigarette per day
- ☐ None
- ☐ Don't know

51. How much coffee did your adolescent drink?

- ☐ More than 3 cups glasses per day
- ☐ Between 1 and 3 cups per day
- ☐ Less than one cup per day
- ☐ None
- ☐ Don't know

52. How much caffeinated soda did your adolescent drink?

- ☐ More than 3 glasses per day
- ☐ Between 1 and 3 per day
- ☐ Less than one per day
- ☐ None
- ☐ Don't know

53. How much time does your adolescent spend on the computer on school days?

☐ 0-2 hours per day　☐ between 2 and 4 hours　☐ between 4 and 6 hours
☐ between 6 and 8 hours　☐ more than 8 hours　☐ don't know

54. How much time does your adolescent spend on the computer on weekend days?

☐ 0-2 hours per day ☐ between 2 and 4 hours ☐ between 4 and 6 hours
☐ between 6 and 8 hours ☐ more than 8 hours ☐ don't know

DEVELOPMENT HISTORY- PART A

55. In what grade is your adolescent currently enrolled? __________ grade

56. What school does your adolescent attend this year?______________________________

57. Has your adolescent been diagnosed with:

	YES	NO	COMMENTS
a. dyslexia	☐	☐	________
b. a speech impairment	☐	☐	________
c. mental retardation	☐	☐	________
d. a behavior disorder	☐	☐	________
e. attention deficit disorder	☐	☐	________
f. other learning disorder (please specify)________	☐	☐	________

58. Is your adolescent enrolled in any special education (special needs) classes in school?
☐ Yes ☐ No Please describe: ______________________________

59. Does your adolescent have an Individualized Education Plan (I.E.P.) provided by the school?
☐ Yes ☐ No If yes, for what reason: ______________________________

60. Generally, how often does your adolescent attend school?
   a. ☐ Every day
   b. ☐ 3-4 days per week
   c. ☐ 1-2 days per week
   d. ☐ Less than once per week

61. Generally, how often is your adolescent late to school?
   a. ☐ Every day
   b. ☐ 3-4 days per week
   c. ☐ 1-2 days per week
   d. ☐ Less than once per week

DEVELOPMENTAL HISTORY- PART B

62. Does your adolescent have any significant behavioral or mental health problems

Yes ☐ No ☐

If yes, please describe ____

____

63. Has your adolescent ever received counseling for behavioral or mental health problems?
Yes ☐ No ☐ If so, for what reason? ____
Please give approximate dates:

____

64. Have <u>you</u> or <u>your spouse</u> ever been seen by a mental health counselor for concerns regarding your adolescent? Yes ☐ No ☐

If yes, for what reason? ____

65. To what organized groups does your adolescent currently belong? (e.g., team sports, scouts, church, groups, etc.) ____

____

SLEEP BELIEFS

In order to better understand your sense of the average teenager's sleep, please answer the following questions based on your beliefs for an <u>average</u> teenager (your adolescent's age) who does <u>not</u> have sleep problems?

a. How many hours of sleep per night does the average teenager get? _______ hours
b. How long does it take the average teenager to get to sleep? _______ minutes
c. How many times does the average teenager wake up during the night? ______ times
d. How long does the average teenager spend awake in bed during the night?
_____ minutes or _____ hours
e. Do you think most teenagers get enough sleep? Yes ☐ No ☐ Don't Know ☐

THANK YOU VERY MUCH FOR YOUR TIME!