

Sleep History Intake Form

Child's Name:

Date:

Date of Birth:

Age:

Gender:

Email:

Is email a good way to contact you? Yes No

Pediatrician:

Who referred you to our practice?

Please list in your own words the **sleep problems** that have prompted you to seek this evaluation

Does your child have any medical problems or developmental problems that you believe impact his or her ability to sleep at night?

In order for us to meet your concerns and to screen your child for any unrecognized problems.

Please complete this questionnaire for us.

Directions: Please circle items about which you have any concerns or questions

0-3 years old

<p>Constitutional/General</p> <ul style="list-style-type: none"> Fussiness Fever Sleep problems Not eating well 	<p>Cardiovascular</p> <ul style="list-style-type: none"> Excessive sweating while eating Breathing too fast Blue spells 	<p>Endocrine</p> <ul style="list-style-type: none"> Growth 	<p>Musculoskeletal</p> <ul style="list-style-type: none"> Feet turning in or out Limp
<p>Eyes</p> <ul style="list-style-type: none"> Eye drainage Lazy eye Concern about vision 	<p>Gastrointestinal</p> <ul style="list-style-type: none"> Vomiting Constipation Diarrhea Stomach pain Appetite 	<p>Neurological</p> <ul style="list-style-type: none"> Headache Weakness 	<p>Provider Comments:</p>
<p>Ear, Nose, Throat</p> <ul style="list-style-type: none"> Concern about hearing Frequent ear infections Concern about teeth Bad snoring Gasping during sleep 	<p>Genitals Urinary</p> <ul style="list-style-type: none"> Painful urination <i>Boys:</i> <ul style="list-style-type: none"> Concerns about circumcision Concerns about care of penis <i>Girls:</i> <ul style="list-style-type: none"> Vaginal irritation 	<p>Development</p> <ul style="list-style-type: none"> Ability to lean Behavior Activity level Mood 	
<p>Respiratory</p> <ul style="list-style-type: none"> Wheeze Difficulty breathing Choking with eating 	<p>Skin</p> <ul style="list-style-type: none"> Diaper rash Skin rash Itching 	<p>Lymphatic/Hematology</p> <ul style="list-style-type: none"> Swollen glands Easy bruising Pale color 	

Family Medical History

Does anyone in your family have the following problems? Please include siblings, parents, grandparents, aunts/uncles and first cousins only.

	No	Yes	Please tell us who and from what side of your family (mother's side or father's side)
Obesity			
Diabetes			
Heart problems			
Strokes			
High Cholesterol			
High blood pressure			
Asthma			
Allergies			
Cancer (please indicate type)			
Stomach or bowel problems			
Kidney or bladder problems			
Scoliosis			
Arthritis			
Migraines or significant headaches			
Seizures			
Neurologic problems such as Cerebral Palsy, mental retardation, Spina bifida or other			
Learning difficulties			
ADHD			
Autism			
Autism			
Emotional or psychiatric problems such as depression, anxiety, bipolar disorder, schizophrenia or other			
Substance abuse problem with alcohol or drugs			

Please list anything else that runs in your family or that you think may be important: _____

Date: _____

Initials: _____