PennState Health
Milton S. Hershey
Medical Center

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?

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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**
4-12 years old

Constitutional/General	**Cardiovascular**	**Musculoskeletal**	**Endocrine**
• Fever • Excessive sweating • Sleep problems	• Chest pain • Fainting • Exercise/endurance	• Back pain • Walking • Sprains or strains	• Weight gain • Weight loss • Excessive thirst • Excessive hunger • Growth
Eyes • Trouble seeing • Eyes crossing • Red eyes • Squinting • Excessive blinking	**Gastrointestinal** • Vomiting • Diarrhea • Constipation • Stomach pain • Appetite	**Neurological** • Headache • Balance • Coordination • Weakness • Spacing out	**Provider Comments:**
Ear, Nose, Throat • Hearing problems • Ear pain • Large tonsils • Frequent throat infections • Bad snoring • Gasping during sleep • Nose bleeds • Dental problems • Frequent ear infections	**Genitals Urinary** • Good urine system • Frequent daytime urination • Frequent nighttime urination • Pain with urination • Circumcision • Care of penis • Vaginal irritation • Bedwetting • Daytime wetting	**Development** • Behavior • Ability to lean • Activity level • Mood • Concentration • School performance **Lymphatic/Hematology** • Swollen glands • Easy bruising • Bleeding • Pale color	
Respiratory • Shortness of breath with exercise • Wheeze • Night coughs for over 2 weeks • Difficulty breathing	**Skin** • Birthmarks • Warts • Skin rash • Itching	**Allergy** • Sneezing • Itchy eyes or nose • Hives • Nasal congestions	

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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: _____