Dr. John L. Corbett
Credentialled Sleep Physician

Dr. Sean L. Tolhurst
Credentialled Sleep Physician

CONFIDENTIAL PATIENT QUESTIONNAIRE – CHILDREN

The following information is requested to comply with National Privacy Principles, to ensure that your child is correctly identified in our records, and to assist us in giving your child the best possible care. All of the information that you provide will be considered as being strictly confidential. If you do not understand any question, please ask one of our staff to explain it.

Please write in black ink pen and bring the completed questionnaire with you to your child's sleep-study

Title: ________ **Patient's Name:** ____ **Age:** ________

Date of Birth: ____

Home Address: ____

____ **Post Code:**_______________

Postal Address (if different from above): ____

Email Address: ____

Parent/Guardian Contact Details:

Phone (Home): __________________ **Phone (Work):** ____________ **Phone (Mobile):** _________________

Emergency Contact Details (name and day/night-time telephone numbers): _________________________

____

Referring Doctor's Name and Address: ____

General Practitioner (if different from above): ____

Specialists your child is currently seeing: ____

Medicare Number: _________________________________**Expiry Date:** ______________**Ref No.:** _____

Health Fund: _______________________________**Membership No** ______________________________

I hereby consent to: a polysomnographic sleep study and video recording of my child during the study, follow-up contact(s) from SNORE Australia, and my child's medial details and sleep report(s) being released to the referring medical practitioner(s) and to any other medial professional(s) to whom my child is referred in the future. I also give consent for SNORE Australia to obtain my child's medical records from other health professionals.

Signed: ____ **Date:** ________________________________

INSTRUCTIONS

Please answer every question, unless you are certain that a question does not apply, in which case leave it blank. Please circle your answers and write any additional comments where necessary.

SCALE: 0 = Never 1 = Sometimes 2 = Usually 3 = Always

Tiredness

Does your child wake **unrefreshed**? 0 1 2 3

Does your child have a problem with **awakening** in the morning? 0 1 2 3

Does your child **feel sleepy** during the day? 0 1 2 3

Does your child have significant problems with **memory** and/or **concentration**? 0 1 2 3

Is your child's **school work** affected by daytime tiredness? 0 1 2 3

If yes, how? ____________________

Does your child exhibit **hyperactive, impulsive,** and/or **aggressive behaviour** (please give details)

____

____

Does your child have **daytime naps**? Average daily number of naps: ________ Total nap hours per day: ______

Sleep Habits

Does your child drink **stimulant drinks** (tea, coffee, cola, energy drinks) during the day? Average number: ______

At **what time** does your child usually drink their last stimulant drink? ____________________

At what time does your child usually **retire to bed**? ____________________

At what time does your child usually **rise in the morning?** ____________________

How many **total hours of sleep** does your child get during the night? ____________________

Do you feel that your child gets **enough sleep on a typical night**? ☐ Yes ☐ No

Do you feel that your child has **insomnia** (significant difficulties getting to and/or staying asleep)? ☐ Yes ☐ No

Approximately **how long** does it take your child to **get to sleep** at night? ____________________

Does your child have **long wakeful periods** during the night that are a problem? Total hours awake: __________

If yes, explain why: ____________________

____

Does your child **wet the bed** at night (**enuresis**)? ☐ Yes ☐ No

Is your child frequently troubled by **bad dreams or nightmares**? ☐ Yes ☐ No

Sleeping Position

Does your child have a **preferred sleeping position**? ☐ Side ☐ Front ☐ Back ☐ None

Would your child be **able to sleep exclusively on their side** if this could help their sleep? ☐ Yes ☐ No

If not, please explain why: ____________________

Restless Legs / Peripheral Nerves

Does your child get an **irresistible urge to move their legs** or **uncomfortable sensations** in their legs when they sit down and relax at the end of the day or when they retire to bed at night? ☐ Yes ☐ No

Have you observed your child **kicking or moving excessively** during sleep? ☐ Yes ☐ No

Does your child get **numbness or "*pins and needles*"** sensations in their hands or feet? ☐ Yes ☐ No

Are similar symptoms present in either parent? (if yes, which parent?) ____________________

Any additional comments: ____________________

____

Body Weight

What is your child's current **body weight**? ___________kg

Amount of **weight gain** in past 12 months: ______kg or Amount of **weight loss** past 12 months: __________kg

Breathing and Nasal Air-flow

Has your child's **tonsils** and/or **adenoids** been removed? ☐ Yes ☐ No

Does your child's **nose regularly block** when trying to sleep? ☐ Yes ☐ No

Is **nasal congestion** a **significant problem** for your child during the day? ☐ Yes ☐ No

Does your child use any **nasal sprays** or medications for nasal allergies (allergic rhinitis)? ☐ Yes ☐ No

If yes, please state what your child uses: ______________________________

Has your child been seen by an **orthodontist**? ☐ Yes ☐ No

Does your child have **dental braces** or **an orthodontic plate**? ☐ Yes ☐ No

Does your child **grind their teeth** during sleep (**bruxism**)? ☐ Yes ☐ No

During sleep, do you find that your child breathes mostly through their: ☐ Nose ☐ Mouth ☐ Both ☐ Unsure

Has your child ever had any **nasal fractures, septal deviation, nasal** or **sinus operations**? (if yes, give details)

____

Heart and Circulation:

Does your child have **high blood pressure**? ☐ Yes ☐ No ☐ Medicated

Does your child have **high cholesterol** and/or **high blood fats**? ☐ Yes ☐ No ☐ Medicated

Has your child ever had any **heart or circulatory problems?** (if yes, please specify) ______________

____

____

What is the name of your child's **Cardiologist**? ______________________________

Has your child had an **echocardiogram** performed recently? ☐ Yes ☐ No (if yes, where? ______________)

Lung Disease:

Has your child ever had any of the following **lung problems** (please circle)?

Obstructive lung disease (e.g., COPD, asthma), chest wall disease (e.g., kyphoscoliosis), hypercapnic respiratory failure (increased CO_2), emphysema

Details: ______________________________

What is the name of your child's **Respiratory Physician**? ______________________________

General Medical History (please *circle* the condition and indicate approximately when it was diagnosed)

Kidney disease, kidney stones, bladder problems ______________________________

Gastric or duodenal ulcer, bowel disorder, liver disorder ______________________________

Hepatitis A, B, C; contact with HIV / AIDS ______________________________

Anaemia, excessive bleeding, other blood disorder ______________________________

Diabetes, thyroid disorder, other endocrine disorder ______________________________

Anxiety, depression, other psychiatric disorder ______________________________

Arthritis, joint or bone disorder ______________________________

Neuromuscular disease (e.g., muscular dystrophy) ______________________________

Epilepsy, seizures, black-outs, other neurological disorder______________________________

Does your child take any **non-prescribed** or **recreational drugs**?______________________________

Does your child have any **allergies**? ______________________________

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Has your child had any serious **accidents** or **past hospital admissions?** (indicate approximate dates & details)

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____

Please note any **other information** you feel is relevant: ______________________________

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____

Please list all of your child's **current medications**:

Medication Name	*Reason for Medication*	*Dosage*

If there is not enough room on this page to list your medications, please attach a separate sheet.

EPWORTH SLEEPINESS SCALE

In the following situations, please choose how likely your child is to doze off or fall asleep by **circling** the appropriate number.

SCALE:
0 = would never doze
1 = slight chance of dozing
2 = moderate chance of dozing
3 = high chance of dozing

1. Sitting and reading	**0**	**1**	**2**	**3**
2. Watching TV	**0**	**1**	**2**	**3**
3. Sitting quiet in a public place (e.g., theatre or meeting)	**0**	**1**	**2**	**3**
4. As a passenger in a car for an hour without a break	**0**	**1**	**2**	**3**
5. Lying down to rest in the afternoon when circumstances permit	**0**	**1**	**2**	**3**
6. Sitting and talking to someone	**0**	**1**	**2**	**3**
7. Sitting quietly after lunch without alcohol	**0**	**1**	**2**	**3**
8. In a car, while stopped for a few minutes in the traffic	**0**	**1**	**2**	**3**

TOTAL: ________________ out of 24

Who **recommended** that your child have a sleep study? (please circle)

☐ Yourself/Parent ☐ GP ☐ Specialist ☐ Friend ☐ Other family Member

☐ Other: ____

Please note any **other information** you feel is relevant: ____

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Additional Details: *Staff Use Only*

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