Sleep/Wake Disorder Center
Langhorne – Newtown Road – Langhorne PA 19047
Tel: (215) 710-6744 Fax: (215) 710-6695

Pediatric Sleep Study Information Sheet

Study Date:_________________ Time of Arrival to Sleep Lab:______________

A polysomnogram is a test designed to monitor and evaluate your child's sleep characteristics and physical state during sleep. Your child will spend the night in a private bedroom at the sleep center (Parents are more than welcome to stay overnight with the child). Every attempt is made to make your child as comfortable as possible. Small electrodes or sensors will be attached to your child's body to monitor his/her sleep efficiency, breathing patterns, heart function, muscle activity and other parameters. All patients are routinely video taped to correlate body position and movement with physiologic data. Other parameters may be monitored and if so, they will be explained to the parent and child. We need to collect AT LEAST (6) hours of data. Please arrive at the sleep center at the date and time as shown above.

***Light Snacks and Beverages are available before bed.**
***A full complimentary breakfast is available for both the child and parent after the sleep study is completed.**

INSTRUCTIONS:

1. **Please have your child wash their hair the day of the study. Please try not to use hairspray, cream rinse or conditioners for they may interfere with the sensors used during the study.**
2. **Have your child take their regular medications unless instructed otherwise by your child's physician.**
3. **Please try to have your child get a normal night sleep the night before the study. Do not let them take any naps during the day of the study.**
4. **Do not let your child drink any beverages containing caffeine four (4) hours prior to the study.**
5. **Please park in the St. Clare Medical Building parking garage. As you enter the lobby area of the St. Clare Medical Building, we are located in Suite M20 on the ground floor.**
6. **Your child must have a written prescription from the ordering physician with them. If you do not have a written prescription, the sleep study cannot be performed. Please also make sure you have your child's insurance card and referral if required.**
7. **Please complete and bring the enclosed questionnaire with you to the night of your child's study.**
8. **Please bring something to sleep in (pajamas, tee-shirt, shorts or what ever your child is comfortable in).**
9. **There is a TV/VCR/DVD in the room. You may bring a movie, something to read, or toys to the night of your child's study. Also feel free to bring your child's own pillow or blanket for his/her comfort.**
10. **Private bathroom facilities are provided for your convenience.**

Pediatric Sleep Evaluation Questionnaire

Accredited by the American Academy of Sleep Medicine

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Child's Information	
Name:	**Date of Birth:**
Gender: **Male / Female**	**Age:**
Address:	**Parents Name(s):**
Social Security #	**Phone: (H)________________________** **(W) ________________________** **(C)________________________**

Insurance Information

Insurance Company Name:____
Insurance Company Address:_____________________________________
Insurance Company Phone:____

Policy#:____________________________   Group#:__________________________
Name of Insured:___________________   Relation:_________________________

Physician Information

Referring Physician:_____________________________Phone#:_________________
Address:____
Primary Care Physician:_________________________ Phone#:_________________
Address:____

May we contact your child's physician for further information? Yes_____ No_____

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It is important for you to be as accurate as possible in answering the following questions. The purpose of this questionnaire is to get a total picture of your child's background and the nature of your child's present problem. Please complete these questions as thoroughly as you can. This information will be held in strict confidence.

In your own words describe your major concern(s) about your child's sleep, including when and how this began and what treatment your child has received in the past.

Child's Sleep History

1. Does your child have a regular bedtime? Yes / No

2. Is the parent in the room when the child falls asleep at home? Yes / No

3. Does the child have their own room? Yes / No

4. Does your child drink caffeinated beverages? Yes / No

Sleep Schedule:

Weekday:

During a 24 hour period what is the amount of time your child sleep's on weekdays: _______hrs.________minutes

The child's usual bedtime on weekday nights : ______:______

The child's usual wake time on weekday mornings: ______:______

Weekend:

During a 24 hour period what is the amount of time your child sleep's on weekends: _______hrs.________minutes

The child's usual bedtime on weekend nights : ______:______

The child's usual wake time on weekend mornings: ______:______

Naps:

How many naps does your child take during the day: 1 / 2 / 3 / 4 / 5 / 6 / 7 / 8 / 9 / 10

What is your child usual nap time: _________:________ am / pm TO _________ : __________ am / pm
_________:________ am / pm TO _________ : __________ am / pm
_________:________ am / pm TO _________ : __________ am / pm

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Child's Sleep Symptoms:

Please circle the appropriate number:

1. **Never**
2. **1 – 2 nights per week**
3. **2 – 3 nights per week**
4. **3 – 4 nights per week**
5. **4 – 5 nights per week**
6. **5 – 6 nights per week**
7. **6 – 7 nights per week**

Difficulty breathing when asleep	1	2	3	4	5	6	7
Stops breathing during sleep							
Snores							
Restless Sleep							
Sweating when sleeping							
Daytime sleepiness							
Poor Appetite							
Nightmares							
Sleepwalking							
Sleep Talking							
Screaming in his/her sleep							
Kicks legs in sleep							
Wakes up at night							
Gets out of bed at night							
Trouble staying in his/her bed							
Resists going to bed at bedtime							
Grinds his/her teeth							
Uncomfortable feeling in his/her legs; creepy-crawling feeling							
Wets bed							

Child's Daytime Symptoms:

Trouble getting up in the morning							
Falls asleep at school							
Naps after school							
Daytime Sleepiness							
Feels weak or loses control of his/her muscles with strong emotions							
Reports unable to move when falling asleep or upon waking							
Sees frightening visual images before falling asleep or upon waking							

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Past Medical History

Please circle any Current or Past Medical Problems that your child incurred (if any) and note date diagnosed.

- **Frequent nasal congestion**_______________
- **Trouble breathing through his/her nose**_______________
- **Sinus problems**_______________
- **Chronic bronchitis or cough**_______________
- **Allergies : (Please Describe)**_______________
- **Asthma**_______________
- **Frequent colds or flu**_______________
- **Frequent ear infections**_______________
- **Frequent strep throat infections**_______________
- **Difficulty swallowing**_______________
- **Acid reflux (gastro esophageal reflux)**_______________
- **Poor or delayed growth**_______________
- **Excessive weight**_______________
- **Hearing problems**_______________
- **Speech problems**_______________
- **Vision problems**_______________
- **Seizures/Epilepsy**_______________
- **Morning headaches**_______________
- **Cerebral palsy**_______________
- **Heart disease**_______________
- **High blood pressure**_______________
- **Sickle cell disease**_______________
- **Genetic disease**_______________
- **Chromosome problem (e.g., Down's)**_______________
- **Skeleton problem (e.g., dwarfism)**_______________
- **Craniofacial disorder (e.g., Pierre-Robin)**_______________
- **Thyroid problems**_______________
- **Eczema (itchy skin)**_______________
- **Pain**_______________
- **Attention Deficit Disorder (ADD)** _______________

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PAST PSYCHIATRIC/PSYCHOLOGICAL HISTORY

Please list your child's past psychiatric/psychological history (if any).

Current Medications

Please list any medications and dose your child is currently taking:

1.____

2.____

3.____

4.____

Family Sleep History

Does any family member have a sleep disorder? Yes / No

If so, who? ____

Please circle the sleep disorder:

- **Insomnia**
- **Snoring**
- **Sleep Apnea**
- **Restless Legs Syndrome**
- **Periodic Limb Movement Disorder**
- **Sleepwalking / Sleep Terrors**
- **Sleep Talking**
- **Narcolepsy**
- **Other:**____

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Epworth Sleepiness Scale

How likely is your child to doze off or fall asleep in the following situations, in contrast to feeling just tired? This refers to your child's usual way of life in recent times. Even if your child has not done some of these things recently, try to work out how they would have affected your child.

Use the following scale to choose the MOST appropriate number for each situation:

0 – Would Never Doze
1 – Slight Chance of Dozing
2 – Moderate Chance of Dozing
3 – High Chance of Dozing

Situation	Chance of Dozing
Sitting and Reading	________________
Watching TV	________________
Sitting inactive in a public place (e.g., Theater or a Classroom)	________________
As a passenger in a car for an hour without a break	________________
Lying down to rest in the afternoon when circumstances permit	________________
Sitting and Talking to Someone	________________
Sitting Quietly after a lunch	________________
In a Car, While stopped for a few minutes in traffic	________________

THANK YOU FOR YOUR COOPERATION