**Wesley Neurology Clinic, PC**
**Marc E. Hofmann, MD, FCCP, FAASM**
**Pediatric Initial Questionnaire**

Name: _____ Date: _____
Insurance Carrier: _____
Birth date: _____ Age: _____ Sex: _____
Parents Marital Status (circle): Single Married Divorced Widowed
Height: _____ Weight: _____ Neck Size: _____
Birth weight: _____ Pregnancy: Normal Difficult Term Pre-term Post-term
Reason for visit:

| General Sleep | | | |
|---|---|---|---|
| Does the child have a regular bedtime routine? | Yes | No | Describe: |
| Does the child have his/her own bed? | Yes | No | |
| Where does the child fall asleep? | | | |
| Who generally puts child to bed? | Mother | Father | Other: |
| How much time does the child spend in bed before going to sleep? | Minutes: _____ | Hours: _____ | |
| Does the child resist going to bed? | Yes | No | Describe: |

| Weekday Sleep History | | |
|---|---|---|
| Total sleep time: | Hours: _____ | Minutes: _____ |
| Usual bedtime on weekdays: | | |
| Usual wake-time on weekdays: | | |

| Weekend/Vacation Sleep Schedule | | |
|---|---|---|
| Total sleep time: | Hours: _____ | Minutes: _____ |
| Usual bedtime on weekend nights: | | |
| Usual wake-time on weekend days: | | |

Does the child engage in activities that keeps him/her from falling asleep at night, such as: (Circle)?

| | | |
|---|---|---|
| Watching TV? | YES | NO |
| Computer usage? | YES | NO |
| Listening to music? | YES | NO |
| Reading? | YES | NO |
| Smoking? | YES | NO |
| Alcohol consumption? | YES | NO |
| Excessive caffeine intake? | YES | NO |
| Excessive eating/drinking? | YES | NO |

Does the child: (Circle)?

| | | |
|---|---|---|
| Stick to a sleep schedule? | YES | NO |
| Get enough morning daylight? | YES | NO |
| Exercise daily? | YES | NO |
| Avoid daytime napping? | YES | NO |
| Avoid post-lunch caffeine? | YES | NO |
| Avoid nighttime nicotine? | YES | NO |
| Wind down before bedtime? | YES | NO |
| Keep room quiet, dark, comfortable? | YES | NO |

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| Current Sleep Symptoms. Please place a check mark in the appropriate box | | | | | | |
|---|---|---|---|---|---|---|
| | **Never** | **Not often <1 night/day per week** | **Sometimes 1-2 nights/days per week** | **Often 3-5 nights/days per week** | **Always 6-7 nights/days per week** | **Do not know** |
| Stops breathing during sleep | | | | | | |
| Difficulty breathing when asleep | | | | | | |
| Snores | | | | | | |
| Restless sleep | | | | | | |
| Sweating when sleeping | | | | | | |
| Daytime sleepiness | | | | | | |
| Poor appetite | | | | | | |
| Has nightmares | | | | | | |
| Sleep walks | | | | | | |
| Sleep talks | | | | | | |
| Screams out during sleep | | | | | | |
| Kicks legs during sleep | | | | | | |
| Wakes during the night | | | | | | |
| Gets out of bed during the night | | | | | | |
| Trouble staying in bed during the night | | | | | | |
| Resists going to bed at bedtime | | | | | | |
| Grinds teeth | | | | | | |
| Uncomfortable feelings in legs; creepy-crawling sensations | | | | | | |
| Wets bed | | | | | | |

Other comments or concerns:

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**Pediatric Initial Questionnaire**

| Current Daytime Symptoms. Please place a check mark in the appropriate box. | | | | | | |
|---|---|---|---|---|---|---|
| | **Never** | **Not often < 1 night/day per week** | **Sometimes 1-2 nights/days per week** | **Often 3-5 nights/days per week** | **Always 6-7 nights/days per week** | **Do not know** |
| Has difficulty getting up in the morning | | | | | | |
| Falls asleep at school | | | | | | |
| Naps after school | | | | | | |
| Has daytime sleepiness | | | | | | |
| Feels weak or loses muscle control with strong emotions | | | | | | |
| Reports unable to move when falling asleep or awakening | | | | | | |
| Sees frightening images when falling asleep or awakening | | | | | | |

| School Performance (if school age, circle as appropriate) | | | | | |
|---|---|---|---|---|---|
| Child's grade? | | | | | |
| Has the child ever repeated a grade? | Yes | No | Which grade? | | |
| Is the child enrolled in special education classes? | Yes | No | | | |
| How many school days missed this year? | None | 1 to 5 | 6 to 10 | 11 to 15 | >16 |
| How many school days missed last year? | None | 1 to 5 | 6 to 10 | 11 to 15 | >16 |
| How many school days was child late this year? | None | 1 to 5 | 6 to 10 | 11 to 15 | >16 |
| How many school days was child late last year? | None | 1 to 5 | 6 to 10 | 11 to 15 | >16 |
| Child's grades this year? | Excellent | Above average | Average | Poor | Failing |
| Child's grades last year? | Excellent | Above average | Average | Poor | Failing |

**Memphis Lung Physicians/Memphis Sleep Diagnostics**
**Marc E. Hofmann, MD, FCCP, FAASM**
**Adult Physical Examination**

| Past Medical History: (Circle) | | | | | | | |
|---|---|---|---|---|---|---|---|
| Chronic bronchitis or cough | Asthma | Obesity | Diabetes | Cholesterol | Stroke | Sleep walking | Parkinson's disease |
| Hyperthyroidism | Hypothyroidism | Heart disease | Cerebral palsy | Cancer | Autoimmune disease | Sleep talking | Dementia |
| Rhinitis/sinusitis | Seizures | GERD | ESRD | Migraine/chronic headaches | Depression | Nightmares | Vision problems |
| Anxiety | Bipolar disorder | Chronic pain | Sleep apnea | Narcolepsy | Insomnia | Depression | Hearing problems |
| Suicide attempt | Psychiatric admission | Chromosomal abnormalities (Down's) | Throat infections | Seasonal allergies | ADD/ADHD | Learning disability | Autism |
| Developmental delay | Hypertension | Other: | | | | | |

| Past Surgical History: (Circle) | | | | | |
|---|---|---|---|---|---|
| Tonsillectomy | Adenoidectomy | Ear tubes | Sinus surgery | Tracheostomy | Head or neck trauma |
| Other: | | | | | |

| Medication History | | | |
|---|---|---|---|
| Name | Dose | Frequency | Reason |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

| Allergy History: |
|---|
| Seasonal allergies: |
| Medication allergies: |

| Family History: (Circle) | | | | | |
|---|---|---|---|---|---|
| Coronary artery disease | Myocardial infarction | Stroke | Hypertension | Diabetes | Asthma |
| COPD | Glaucoma | Kidney disease | Liver disease | Blood clots | Cancer |
| Sleep apnea | Narcolepsy | Insomnia | Restless legs syndrome | Periodic limb movement disorder | Snoring |
| Thyroid disorder | Sleep Walking | Sleep talking | | | |
| Other: | | | | | |

| Occupational History | | |
|---|---|---|
| Does the patient work? | Yes | No |
| What shift? | | |
| What hours? | | |