NORCAL AIRWAY

**Pediatric Patient Heath Questionnaire**

**Name:** _____
**First** **Middle** **Last**

Age:_____Date of Birth: _____SSN:_____Sex: ___Male__Female

Ethnicity: _____American Indian/Alaska Native _____Asian _____Black/African American _____Hispanic/Latino
_____Native Hawaiian/Pacific Islander _____White _____Other _____Decline

Patient Address:_____City:_____State:_____Zip:_____
Home Phone:_____Cell Phone:_____
Email:_____School Attending:_____
Family Dentist:_____Primary Care Doctor:_____
Other Doctors:_____
How did you hear about our office? _____

**Primary Insurance Information:**
Policy Holder:_____Relationship to Patient:_____
Date of Birth:_____SSN:_____Employer:_____Insurance Company:_____
Contract #:_____Group #:_____Provider #:_____

**Additional Insurance Information**
Policy Holder:_____Relationship to Patient:_____
Date of Birth:_____SSN:_____Employer:_____Insurance Company:_____
Contract #:_____Group #:_____Provider #:_____

**Sleep**
What are your major concerns about your child's sleep?_____
_____
What have you previously tried to help this problem?_____
_____

Total estimated amount of sleep on a **weekday** (including naps):_____
Usual bedtime on **weekday** nights:_____
Usual wake time on **weekday** mornings:_____

Total estimated amount of sleep on a **weekend** (including naps):_____
Usual bedtime on **weekend** nights:_____
Usual wake time on **weekend** mornings:_____

**Napping**
Number of days each week that your child takes a nap:_____
Nap times (from when to when):_____

**Please circle to indicate general sleep information**

| | | |
|---|---|---|
| Is there a regular bedtime? | Yes | No |
| Does your child have his/her own bedroom? | Yes | No |
| Does the child have his/her own bed? | Yes | No |
| Is there a parent present when your child falls asleep? | Yes | No |
| Does the child resist going to bed? | Yes | No |
| Does the child have difficulty falling asleep? | Yes | No |
| Does the child awaken during the night? | Yes | No |
| Is this a problem? | Yes | No |
| If awakening at night, does the child have difficulty returning to sleep? | Yes | No |
| Is the child difficult to awaken in the morning? | Yes | No |
| Is the child a poor sleeper? | Yes | No |

**Please circle to indicate the frequency of current sleep symptoms:**

| | | | |
|---|---|---|---|
| Difficulty breathing when asleep? | Never | Occasionally | Frequently |
| Stops breathing during sleep? | Never | Occasionally | Frequently |
| Snores? | Never | Occasionally | Frequently |
| Restless sleep? | Never | Occasionally | Frequently |
| Sweating when sleeping? | Never | Occasionally | Frequently |
| Daytime sleepiness? | Never | Occasionally | Frequently |
| Poor appetite? | Never | Occasionally | Frequently |
| Nightmares? | Never | Occasionally | Frequently |
| Sleepwalking? | Never | Occasionally | Frequently |
| Sleep talking? | Never | Occasionally | Frequently |
| Screaming during sleep? | Never | Occasionally | Frequently |
| Leg kicking during sleep? | Never | Occasionally | Frequently |
| Waking up at night? | Never | Occasionally | Frequently |
| Getting out of bed at night? | Never | Occasionally | Frequently |
| Trouble staying in his/her bed? | Never | Occasionally | Frequently |
| Resistence going to bed? | Never | Occasionally | Frequently |
| Teeth grinding? | Never | Occasionally | Frequently |
| Uncomfortable “creepy-crawly” feeling in his/her legs? | Never | Occasionally | Frequently |
| Bed wetting? | Never | Occasionally | Frequently |

**Please circle to indicate the frequency of current daytime symptoms:**

| | | | |
|---|---|---|---|
| Trouble getting up in the morning? | Never | Occasionally | Frequently |
| Falls asleep at school? | Never | Occasionally | Frequently |
| Naps after school? | Never | Occasionally | Frequently |
| Daytime sleepiness? | Never | Occasionally | Frequently |

Feels week or loses control of his/her muscles with strong emotions? Never Occasionally Frequently

Reports being unable to move when falling asleep or upon waking? Never Occasionally Frequently

**Family History**

Mother's Age:_____
Mother's Education:_____
Mother's Occupation:_____
Father's Age:_____
Father's Education:_____
Father's Occupation:_____
Other persons living in the home:_____

Does anyone in the family have a sleep disorder? Yes No
If yes, who and what disorder?_____

**Medical History**

Mother's Pregnancy: _____Normal _____Difficult
Delivery: _____Term _____Pre-term _____Post-term
Is this an only child? _____Yes _____No

**Does the child or has the child experienced any of the following?**

_____Frequent nasal congestion
_____Trouble breathing through his/her nose
_____Sinus problems
_____Chronic bronchitis or cough
_____Environmental allergies
_____Asthma
_____Frequent cold or flus
_____Frequent ear infections
_____Frequent strep throat infections
_____Difficulty swallowing
_____Acid reflux (gastroesophageal 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
_____Skeleton problem
_____Craniofacial disorder
_____Thyroid problem
_____Eczema
_____Pain

If the child has a long-term medical problems, list the three that you think are the most important:

1._____
2._____
3._____

**Please indicate the child has experienced any of the following.**

_____Autism
_____Developmental Delay
_____Hyperactivity/ADHD
_____Anxiety/Panic attacks
_____Obsessive Compulsive Disorder
_____Depression
_____Learning Disabilities
_____Drug use/abuse
_____Behavior Disorder
_____Psychiatric admission

**Please circle to indicated past surgical history**

| | | |
|---|---|---|
| Has your child ever had his/her tonsils removed? | Yes | No |
| Has your child ever had his/her adenoids removed? | Yes | No |
| Has your child eve had ear tubes? | Yes | No |

What other surgeries has your child had (include age when surgery was performed)?_____

_____

**Medications**

Please indicate medication names, dosage and how often it is taken:_____

Please indicate any allergies to medications:_____

Please indicate any know environmental allergies:_____