



Pediatric Sleep Lab History Form

Name _____ Parent/Guardian _____
 Home Phone _____ Address _____
 Date of Birth _____ Height _____ cm Weight _____ Kg Tanner Stage _____
 Referring Physician _____ Phone _____ Fax _____

Sleep History

Bedtime School Nights _____ Non school nights _____
 Wake time school days _____ Non school days _____
 Average time to fall asleep _____ Restlessness in legs prior to sleep Yes No
 Frequently falls asleep with blanket rocking patting
 Snoring: How loud None Mild Moderate Severe
 How frequent None Occasional Frequent
 Only on back In all positions
 Restless sleep (frequent tossing & turning) Yes No Mouth breathing Yes No
 Frequent congestion Yes No Wheezing/stridor Yes No
 Shallow breathing followed by movement Yes No Stops breathing Yes No
 Sleeping with knees tucked under stomach (prayer position) Yes No
 Awakens crying/confused at night Yes No Regurgitation Yes No
 Awakens: Tired Sluggish but happy Ready to go/alert
 Sleepy: In school Car trips of 15 mins or more Watching TV

Daytime Naps Number of: _____ Length: _____
 Cataplexy (sudden loss of muscle strength) Yes No
 Hypnagogic hallucinations Yes No Sleep paralysis Yes No

Medical History

Current Medications _____

Significant surgeries _____

Significant illnesses _____

ENT exam: tonsils and adenoids present? Yes No Enlarged Yes No

Explain: _____

Additional medical History: _____

Home CPAP/BIPAP Settings _____ cms Home Oxygen _____ lpm

Tracheostomy: size _____ Type of trach _____

Craniofacial anomaly _____

Purpose of Study Evaluate for sleep disorder breathing _____

Type of Study

Polysomnography: Overnight _____ Reflux testing: _____

CPAP Titration: Yes No Starting pressure: _____ cm

Oxygen titration: Yes No Start _____ lpm/FiO2

**FORM COMPLETION IS NECESSARY TO INSURE APPROPRIATE TESTING,
 ACCURATE INTERPRETATION AND RELEVANT RECOMMENDATIONS FOR TREATMENT**

ORDERING PHYSICIAN'S SIGNATURE _____