A sleep study 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 lab. We have reserved a separate private bedroom for parents who wish to stay overnight.

There will be several small sensors placed on your child's scalp, face, chest, abdomen and legs. The purpose of these sensors is to monitor their brain activity, eye movements, muscle activity, heart function and respiration. Other parameters may be monitored and if so, they will be explained to you and your child.

Note: Light snacks and beverages are available before bed.

Instructions:

1. Please have your child bathed and hair washed the day of the study. Do not use lotion, hairspray or conditioner 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 a nap during the day of the study.

4. Do not let your child drink any beverages containing caffeine after 12 noon the day of the study.

5. Please bring something to sleep in: pajamas, tee-shirt, shorts, or whatever your child is comfortable in (no silk pajamas please)

6. There is a television in the room. You may bring something to read or toys to the lab. Feel free to bring your child's pillow and blanket for his/her comfort.

7. Please bring your child's insurance card with you. There will be a separate charge for the physician interpretation of your child's study. For more information, call 812-353-5769 or visit www.iuhealth.org.

8. Please complete and bring this questionnaire with you.

9. You will be ready to leave by 6:30 AM in the morning following the test.

10. It is important that you arrive on time for your appointment. If you cannot keep your appointment, please call 48 hours in advance to reschedule or cancel.

11. Please park in the Parking Garage and follow the adjoining walk-way into the hospital. Then follow the signs to elevator “B”. Take the elevator to the second floor. The lab is located around the corner to the right as you get off the elevators.
We are here to be of service to you and your child. If you have any questions, please feel free to contact us Monday through Friday from 8:30 AM to 5:00 PM at 812-353-5740.

Thank you for your cooperation.

Appointment Date ______________________

Appointment Time ______________________

Please bring the following with you to the Sleep Lab:

1. Comfortable sleepwear (no silk pajamas please as they can interfere with the study)
2. Favorite pillow and/or blanket, if you choose
3. Toiletries; toothbrush/paste, comb/brush
4. Clothes to go home in
5. Medications that you will need during your study
6. Reading material, if you choose
7. Insurance card
8. This completed Pediatric Medical History Questionnaire
9. The Sleep Lab provides sheets, blankets, pillows, and towels.
Date ______________________

Name _______________________________________

Date of Birth ____________________

Address _____________________________________

Home Phone ____________________

Cell Phone ____________________

Occupation ________________________________

Sex: ☐ Male ☐ Female

---

**Health Status**

1. Height _______________ inches

2. Weight _______________ pounds
   A. Has child’s weight changed in the last year? + (gained) _____ lbs - (lost) _____ lbs
   B. Has child’s weight changed in the last 4 months? + (gained) _____ lbs - (lost) _____ lbs

3. Neck size _______________ inches

4. Is child in good health? ☐ Yes ☐ No

5. Give the year of your child’s last physical examination ____________________________

   Any abnormalities ________________________________________________________________

6. Please list any health problems ___________________________________________________

   ________________________________________________________________________________

<table>
<thead>
<tr>
<th>Surgical Operations</th>
<th>Dates</th>
<th>Physician, Clinic or Hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Allergies (food, drug, etc.)</th>
<th></th>
<th></th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Previous EEG’s or Sleep Recordings</th>
<th></th>
<th></th>
</tr>
</thead>
</table>

☐ M ☐ F __________ Age

Admission Number __________ Date __________ Birth Date __________

Patient Identification Medical Record Number

185457  4/11/11 PEDIATRIC MEDICAL HISTORY QUESTIONNAIRE
7. How much of these beverages does the child consume?
   - Chocolate Milk: _____ Cups/day  Cups after 6:00 PM _____
   - Coffee/Tea: _____ Cups/day  Cups after 6:00 PM _____
   - Caffeinated soda: _____ Drinks/day  Drinks after 6:00 PM _____

8. Name and address of personal or family physician __________________________________________

9. Please list any other doctor you wish to receive results of this test ____________________________

   In your 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

Patient-Last Name, First Name, Middle Initial: □ M  □ F  Age __________________
Admission Number: __________________  Date: __________________  Birth Date: __________________
Physician Name: __________________

Patient Identification: 185457  4/11/11  Medical Record Number: __________________
SLEEP SCHEDULE

Weekday:
During the 24-hour period what is the amount of time your child sleeps on weekdays:

____ hours ____ minutes

The child's usual bedtime on weekday nights: ___:___ PM

The child's usual wake time on weekday morning: ___:___ AM

Weekend:
During the 24-hour period what is the amount of time your child sleeps on weekends:

____ hours ____ minutes

The child's usual bedtime on weekend nights: ___:___ PM

The child's usual wake time on weekend morning: ___:___ AM

Naps:
How many naps does your child take during the day? ☐ None  ☐ 1 – 2  ☐ 3 or more

What is your child's usual nap time:

_____ AM / PM to _____ AM / PM

_____ AM / PM to _____ AM / PM

_____ AM / PM to _____ AM / PM
**Child’s Sleep Symptoms**

Please check the appropriate number:
1. Never
2. Few times a week
3. Often

<table>
<thead>
<tr>
<th>Difficulty breathing when asleep</th>
<th>1</th>
<th>2</th>
<th>3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stops breathing during sleep</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Snores</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Restless Sleep</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sweating when sleeping</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Daytime sleepiness</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Poor appetite</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nightmares</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sleepwalking</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sleep talking</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Screaming in his/her sleep</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kicks legs in sleep</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Wakes up in sleep</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Wakes up at night</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Get out of bed at night</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Trouble staying in his/her bed</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Resists going to bed at bedtime</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Grinds his/her teeth</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Uncomfortable feeling in his/her legs; creepy-crawling feeling</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Wets bed</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Child’s Daytime Symptoms**

<table>
<thead>
<tr>
<th>Trouble getting up in the morning</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Falls asleep at school</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Naps after school</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Daytime sleepiness</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Feels weak or loses control of his/her muscles with strong emotion</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reports unable to move when falling asleep or upon waking</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sees frightening visual images before falling asleep or upon waking</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

---

Patient-Last Name, First Name, Middle Initial  □ M □ F Age

<table>
<thead>
<tr>
<th>Admission Number</th>
<th>Date</th>
<th>Birth Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Physician Name

Patient Identification  Medical Record Number

185457  4/11/11
### Past Medical History

Please check any CURRENT or PAST medical problems that your child incurred (if any) and note the date diagnosed.

- [ ] Frequent nasal congestion
- [ ] Trouble breathing through his/her nose
- [ ] Sinus problems
- [ ] Chronic bronchitis or cough
- [ ] Allergies: (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
- [ ] Seizure / Epilepsy
- [ ] Morning headaches
- [ ] Cerebral palsy
- [ ] Heart disease
- [ ] High blood pressure
- [ ] Sickle cell disease
- [ ] Genetic disease
- [ ] Chromosome problems (e.g., Down Syndrome)
- [ ] Skeleton problems (e.g., dwarfism)
- [ ] Craniofacial disorder (e.g., Pierre-Robin)
- [ ] Thyroid problems
- [ ] Eczema (itchy skin)
- [ ] Pain
- [ ] Attention Deficit Hyperactivity Disorder (ADHD)
- [ ] Other

---

**Patient-Identification**

- **Patient-Last Name, First Name, Middle Initial**: [ ] M [ ] F Age
- **Admission Number**: 185457
- **Date**: 4/11/11
- **Birth Date**:____________________
- **Physician Name**: ______________________
- **Medical Record Number**: 5 of 7
Past Psychiatric/Psychological History

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

Current Medications

Please list any over-the-counter drugs or prescribed medications and the dose of each that your child is currently taking:

<table>
<thead>
<tr>
<th>Names of Medication</th>
<th>Doses</th>
<th>Times Per Day</th>
<th>For What Reason</th>
<th>Length of Time Used</th>
<th>Prescribing Physician</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Family Sleep History

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

If so, who? __________________________________________________________________________

Please check the sleep disorder:
☐ Insomnia
☐ Snoring
☐ Sleep Apnea
☐ Restless Leg Syndrome
☐ Periodic Limb Movement Disorder
☐ Sleepwalking / Sleep Terrors
☐ Sleep Talking
☐ Narcolepsy
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

<table>
<thead>
<tr>
<th>Situation</th>
<th>Chance of Dozing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sitting and reading</td>
<td>0 1 2 3</td>
</tr>
<tr>
<td>Watching TV</td>
<td>0 1 2 3</td>
</tr>
<tr>
<td>Sitting inactive in a public place (e.g. a theater or a meeting)</td>
<td>0 1 2 3</td>
</tr>
<tr>
<td>As a passenger in a car for an hour without a break</td>
<td>0 1 2 3</td>
</tr>
<tr>
<td>Lying down to rest in the afternoon when circumstances permit</td>
<td>0 1 2 3</td>
</tr>
<tr>
<td>Sitting and talking to someone</td>
<td>0 1 2 3</td>
</tr>
<tr>
<td>Sitting quietly after a lunch</td>
<td>0 1 2 3</td>
</tr>
<tr>
<td>In a car, while stopped for a few minutes in traffic</td>
<td>0 1 2 3</td>
</tr>
<tr>
<td>TOTAL</td>
<td></td>
</tr>
</tbody>
</table>

0 = no chance of dozing
1 = slight chance of dozing
2 = moderate chance of dozing
3 = high chance of dozing