

SLEEP SCHEDULE

	School Days	Weekends
What time does your child go to bed?	_____ am/pm	_____ am/pm
What time does your child get out of bed?	_____ am/pm	_____ am/pm
How long do you think it takes your child to fall asleep?	_____ min	_____ min
On average, how many hours of actual sleep do you think your child gets every night?	_____ hrs	_____ hrs
How many days out of the week does your child take a nap? At what time does he/she take a nap?	1 2 3 4 5 6 7	_____

MEDICAL HISTORY

Place a check mark in the box next to all of the problems your child has:

YES		YES	
<input type="checkbox"/>	hypertension (high blood pressure)	<input type="checkbox"/>	craniofacial abnormalities
<input type="checkbox"/>	heart disease	<input type="checkbox"/>	skeletal problems / dwarfism
<input type="checkbox"/>	asthma or other lung disease	<input type="checkbox"/>	delayed growth
<input type="checkbox"/>	ear infections	<input type="checkbox"/>	learning disability
<input type="checkbox"/>	sinus disease	<input type="checkbox"/>	behavioral disorder
<input type="checkbox"/>	reflux	<input type="checkbox"/>	anxiety / panic attacks
<input type="checkbox"/>	seizures	<input type="checkbox"/>	depression
<input type="checkbox"/>	sickle cell anemia	<input type="checkbox"/>	obsessive compulsive disorder
<input type="checkbox"/>	diabetes	<input type="checkbox"/>	chromosome problem (like Down syndrome)
<input type="checkbox"/>	vision problems	<input type="checkbox"/>	genetic disorder
<input type="checkbox"/>	hearing problems	<input type="checkbox"/>	hyperactivity / ADHD
<input type="checkbox"/>	thyroid disease	<input type="checkbox"/>	premature birth
<input type="checkbox"/>	acute life threatening event ("near SIDS")		

Does your child have other medical problems? If so, please list them here:

SURGICAL HISTORY

Has your child ever had:

- tonsillectomy (tonsils taken out)
- ear tubes
- tracheostomy
- face / jaw surgery

Has your child had other surgeries? If so, please list them here:

Please list all your child's doctors

_____	_____	_____
Name	Specialty	Phone
_____	_____	_____
Name	Specialty	Phone
_____	_____	_____
Name	Specialty	Phone
_____	_____	_____
Name	Specialty	Phone

MEDICATIONS

List the medications that your child currently takes (including the ones you can get without a prescription):

Name	Dose	Name	Dose
Name	Dose	Name	Dose
Name	Dose	Name	Dose
Name	Dose	Name	Dose

ALLERGIES

Please list all drugs that your child is allergic to: _____

SOCIAL HISTORY

Who else lives in the same house as your child?: _____

HABITS

How much of the following does your child use:

	Weekdays	Weekend days
Coffee	_____	_____
Tea	_____	_____
Chocolate	_____	_____
Caffeinated soda (pop)	_____	_____
Recreational drugs	_____	_____
Cigarettes	_____	_____

SCHOOL HISTORY

Current grade:

Has your child ever repeated a grade? Yes No

Is your child enrolled in any special education classes? Yes No

Grades this year: Excellent Good Average Poor Failing

Grades last year: Excellent Good Average Poor Failing

FAMILY HISTORY

Yes No Does anyone in your child's family snore or have sleep apnea, narcolepsy, insomnia or other sleep disorders?

If yes, please list: _____

Yes No Has anyone in your child's family been diagnosed with one of the disorders listed under the medical history?

If yes, please list: _____

Marital status of parents: Married Single Separated Divorced

Mother's occupation: _____ Father's occupation: _____