EPWORTH SLEEPINESS SCALE
FOR CHILDREN AND ADOLESCENTS

Name_____DOB_____

Date _____Gender_____

How likely are you to doze off or fall asleep in the situations described below, in contrast to feeling just tired?

Even if you have not done some of these things in the last month, try to imagine how they would have affected you.

Use the following scale to choose the **most appropriate number** for each situation:

0 - Would **never** doze

1 - **Slight** chance of dozing

2 - **Moderate** chance of dozing

3 - **High** chance of dozing

*****It is important that you answer each question as best as you can.*****

Situation	Chance of dozing (out of 3)
Sitting and reading	
Sitting and watching TV or a video	
Sitting in a classroom at school during the morning	
Sitting and riding in a car or bus for about half an hour	
Lying down to rest or nap in the afternoon	
Sitting and talking to someone	
Sitting quietly by yourself after lunch	
Sitting and eating a meal	
Total out of 24	

Score Interpretation: (1-10) Normal Range (10–16) Excessively sleepy (16-24) Abnormally sleepy

Children and Adolescents

Sleep, Breathing & Habit Questionnaire

Patient's Name: _____ Age: _____ Date: _____

Please indicate if your child experiences or has experienced any of the symptoms below by using this scale to measure the severity of these symptoms.

0 - No Occurrence ***1 - Occurs Rarely*** ***2 - Occurs 2 to 4 times per week*** ***3 - Occurs 5 to 7 times per week***

1. _____ Snoring
2. _____ Interrupted snoring where breathing stops
3. _____ Labored, difficult or loud breathing at night
4. _____ Gasping for air while sleeping
5. _____ Mouth breathes while sleeping
6. _____ Mouth breathes during the day
7. _____ Restless sleep
8. _____ Grinds teeth while sleeping
9. _____ Talks in sleep
10. _____ Excessive sweating while sleeping
11. _____ Wakes up at night
12. _____ Wets the bed (currently)
13. _____ History of bedwetting
14. _____ Feels sleepy and/or irritable during the day
15. _____ Headaches
16. _____ Frequent throat infections
17. _____ Seasonal allergies
18. _____ Ear infections or history of ear infections
19. _____ Short attention span
20. _____ Trouble Focusing
21. _____ Difficulty listening/often interupts
22. _____ Hyperactive
23. _____ ADD/ADHD
24. _____ Sensory issues
25. _____ Struggles in math at school
26. _____ Struggles in reading at school
27. _____ Speech issues *
28. _____ Avoidance behavior towards food or or certain types of food

*Speech Questionnaire - to be filled out only if #27 was indicated above

Please check all that apply to your child

_____ Is it difficult to understand your child's speech?

_____ Difficult to understand over the phone?

_____ Nasal speech?

_____ Hoarseness?

_____ Others have difficulty understanding speech?

_____ Gets frustrated when people can't understand speech?

_____ Speech sounds abnormal?

_____ Sometimes omits consonants?

_____ Uses M, N, NG instead of P, V, S, Z sounds?

_____ Liquids and/or solids get into nasal area when eating or drinking?

Child New Patient Medical Background Information

PATIENT INFORMATION

Patient Name: _____ Date of Birth _____/_____/_____

Parent or Guardian's Name: _____

Chief Complaint or Concern:

_____

_____

_____

MEDICATIONS (including prescription and over-the-counter)

1._____ 5._____

2._____ 6._____

3._____ 7._____

4._____ 8._____

Does your child have any allergies to any medications? ❑ Yes ❑ No

If yes – please list:

_____

_____

PAST SURGICAL HISTORY

1._____ 5._____

2._____ 6._____

3._____ 7._____

4._____ 8._____

Has your child ever had your tonsils and/or adenoids surgically removed? ❑ Yes ❑ No

ALLERGY HISTORY

❑None Known ❑ Yes, to: 1._____ 3._____

2._____ 4._____

Pets: ❑ No ❑ Yes How many? _____ What type of pet? _____

Do any pets sleep in your child's bedroom? ❑ No ❑ Yes

Which pets? _____

FAMILY HISTORY

Do you have a family history of any of the following medical illnesses? (Check if "yes" to all that apply):

❑ High blood pressure/hypertension	❑ Diabetes	❑ Chronic insomnia
❑ Heart disease	❑ Overweight/obesity	❑ Restless legs syndrome
❑ Stroke	❑ Snoring	❑ Multiple sclerosis
❑ Congestive heart failure	❑ Sleep apnea	❑ Sleep walking
❑ Depression	❑ Anxiety	

REVIEW OF SYMPTOMS

Constitutional:

Loss of Appetite:	❑ Yes ❑ No
Fever:	❑ Yes ❑ No
Fatigue:	❑ Yes ❑ No
Weight Gain:	❑ Yes ❑ No
Weight Loss:	❑ Yes ❑ No

Respiratory:

Cough:	❑ Yes ❑ No
Asthma:	❑ Yes ❑ No
Wheezing:	❑ Yes ❑ No
Poor Exercise Tolerance:	❑ Yes ❑ No

REVIEW OF SYMPTOMS

Gastrointestinal:

Heartburn/Indigestion: ❑ Yes ❑ No

Black or Bloody Stools: Diarrhea: ❑ Yes ❑ No

Nausea/Vomiting: ❑ Yes ❑ No

Jaundice: ❑ Yes ❑ No

Abdominal Pain ❑ Yes ❑ No

Allergy/Immunology:

Nasal allergies/Hay fever/

Nasal Congestion: ❑ Yes ❑ No

Sneezing: ❑ Yes ❑ No

Runny Nose: ❑ Yes ❑ No

Itchy Eyes or Nose: ❑ Yes ❑ No

Hives: ❑ Yes ❑ No

Eyes:

Blurry Vision: ❑ Yes ❑ No

Double Vision: ❑ Yes ❑ No

Vision Loss : ❑ Yes ❑ No

Genitourinary:

Frequent Urination ❑ Yes ❑ No

Difficulty Urinating: ❑ Yes ❑ No

Blood in Urine: ❑ Yes ❑ No

Musculoskeletal:

Stiff/Sore Joints: ❑ Yes ❑ No

Muscle Pain: ❑ Yes ❑ No

Red or Swollen Joints: ❑ Yes ❑ No

Temporomandibular Joint

(TMJ) pain/jaw discomfort: ❑ Yes ❑ No

Ears/Nose/Throat/Mouth:

Hearing Loss: ❑ Yes ❑ No

Sore Throat: ❑ Yes ❑ No

Sinus Congestion: ❑ Yes ❑ No

Hoarseness: ❑ Yes ❑ No

Tubes in Ears: ❑ Yes ❑ No

REVIEW OF SYMPTOMS

Cardiac:

Palpitations: ❑ Yes ❑ No

Chest Pain: ❑ Yes ❑ No

Daytime Shortness of Breath: ❑ Yes ❑ No

Nighttime Shortness of Breath: ❑ Yes ❑ No

Ankle Swelling: ❑ Yes ❑ No

Hypertension/High Blood Pressure ❑ Yes ❑No

Skin:

Unusual Moles: ❑ Yes ❑ No

Rash: ❑ Yes ❑ No

Dryness: ❑ Yes ❑ No

Endocrine:

Heat Intolerance ❑ Yes ❑ No

Cold Intolerance: ❑ Yes ❑ No

Excessive Thirst: ❑ Yes ❑ No

Constipation: ❑ Yes ❑ No

Neurologic:

Weakness: ❑ Yes ❑ No

Seizures: ❑ Yes ❑ No

Involuntary Tongue Biting: ❑ Yes ❑ No

Passing Out: ❑ Yes ❑ No

Dizziness: ❑ Yes ❑ No

Headaches: ❑ Yes ❑ No

Numbness: ❑ Yes ❑ No

Psychiatric:

Excessive Stress: ❑ Yes ❑ No

Memory Loss: ❑ Yes ❑ No

Hallucinations: ❑ Yes ❑ No

Nervousness or Anxiety: ❑ Yes ❑ No

Depressed Mood: ❑ Yes ❑ No

Memory Loss: ❑ Yes ❑ No

Was your child breast fed? ❑ Yes ❑ No

If your child was breast fed – for how long? _____

Was your child ❑ Full Term ❑ Premature

If Premature – at how many weeks was your child delivered? _____

THANK YOU FOR TAKING THE TIME TO COMPLETE THIS INFORMATION