Pediatric Comprehensive Health Questionnaire

Demographic Information
☐Mr. ☐Ms. ☐Miss ☐Mrs. ☐Dr.

First Name: _____ Middle Initial: ____ Last Name: _____

Age: _____ Date of Birth: _____ Height: _____ Weight: _____

Ethnicity: ☐Native American/Alaska Native ☐Asian ☐African American ☐Hispanic/Latino ☐Native Hawaiian/Pacific Islander ☐White ☐Other. ☐Decline to Answer

Responsible Party/Legal Guardian (if different than patient): _____ Relationship: _____

Contact Information

Address: _____ Address 2: _____

City: _____ State: _____ Zip: _____

Email: _____ Home/Cell: _____

Employer: _____ Work Phone: _____

Provider Information Referral Source: _____

Dental Provider Office: _____ Last Visit: _____

Dentist Name: _____ Office Phone: _____

City: _____ Sate: _____ Zip: _____

Primary Care Physician Office: _____ Last Visit: _____

Doctor Name: _____ Office Phone: _____

City: _____ Sate: _____ Zip: _____

Additional Provider Office: _____ Last Visit: _____

Doctor Name: _____ Office Phone: _____

City: _____ Sate: _____ Zip: _____

Patient/Parent Signature: _____ Date: _____

What is your chief concern and reason for this visit:

_____

Does your child currently experience any of the following symptoms?

Indicate all that apply and number your top chief complaints 1-4

Sleep Conditions

Regular bedtime	☐Yes ☐No	Resist going to bed	☐Yes ☐No
Difficulty falling asleep	☐Yes ☐No	Awakenings from sleep	☐Yes ☐No
Difficulty awakening in AM	☐Yes ☐No	Poor sleeper	☐Yes ☐No
Snoring	☐Yes ☐No	Mouth breathing	☐Yes ☐No
Restless sleep	☐Yes ☐No	Sweating when sleeping	☐Yes ☐No
Daytime sleepiness	☐Yes ☐No	Poor appetite	☐Yes ☐No
Nightmares	☐Yes ☐No	Sleepwalking	☐Yes ☐No
Sleep talking	☐Yes ☐No	Sleep terrors	☐Yes ☐No
Leg kicking	☐Yes ☐No	Getting out of bed	☐Yes ☐No
Teeth grinding	☐Yes ☐No	Growing pains	☐Yes ☐No
Bed wetting	☐Yes ☐No	Daytime sleepiness	☐Yes ☐No
Naps after school	☐Yes ☐No	Falls asleep at school	☐Yes ☐No

Other _____

Pain Conditions

Headaches	☐Yes ☐No	Jaw pain	☐Yes ☐No
Neck pain	☐Yes ☐No	Back pain	☐Yes ☐No
Noises in jaw joints	☐Yes ☐No	Difficulty opening mouth	☐Yes ☐No
Growing pains	☐Yes ☐No		

Other _____

Other Conditions

Nasal congestion	☐Yes ☐No	Difficulty breathing through nose	☐Yes ☐No
Bronchitis	☐Yes ☐No	Asthma	☐Yes ☐No
Allergies	☐Yes ☐No	Frequent colds or flu	☐Yes ☐No
Ear infections	☐Yes ☐No	Throat infections	☐Yes ☐No
Tonsillitis	☐Yes ☐No	Acid reflux (GERD)	☐Yes ☐No
Delayed growth	☐Yes ☐No	Fussy eater	☐Yes ☐No
Excessive weight	☐Yes ☐No	Tubes in ears	☐Yes ☐No
Hearing disorders	☐Yes ☐No	Speech problems	☐Yes ☐No
Vision problems	☐Yes ☐No	Seizures/epilepsy	☐Yes ☐No
Chromosomal disorders	☐Yes ☐No	Eczema	☐Yes ☐No
Tooth crowding	☐Yes ☐No	Delayed tooth eruption	☐Yes ☐No
Tongue-tie	☐Yes ☐No	Drooling while eating	☐Yes ☐No
Autism	☐Yes ☐No	Developmental delay	☐Yes ☐No
Hyperactivity ADHD	☐Yes ☐No	Anxiety/Panic Attacks	☐Yes ☐No
Obsessive Compulsive Disorder	☐Yes ☐No	Depression	☐Yes ☐No
Learning disability	☐Yes ☐No	Drug abuse	☐Yes ☐No
Behavioral disorder	☐Yes ☐No	Psychiatric care	☐Yes ☐No

Other _____

Surgical History

Tonsils removed	☐Yes ☐No	Adenoids removed	☐Yes ☐No
Tubes in ears	☐Yes ☐No	Tongue-tie release	☐Yes ☐No
Tooth extractions	☐Yes ☐No		

Other _____

What are the results you are seeking from treatment:

_____

Patient/Parent Signature: _____ Date: _____

Allergic Reactions

Please check any and all medications or substance that have caused an allergic reaction

☐ Anesthetics	☐ Antibiotics	☐ Aspirin
☐ Barbiturates	☐ Codeine	☐ Iodine
☐ Latex	☐ Metals	☐ Plastics
☐ Penicillin	☐ Sedatives	☐ Sulfa

☐ Food Allergies/Sensitivities _____

Other: _____

Current Medications

Please list all medications and supplements (over-the-counter and prescription) you are taking and the reason you take them.

Medication	Dosage	Reason for Taking

☐ See attached list

Previous Treatment, Medications and Other Therapies Attempted For The Condition We Are Evaluating

Treatment/Med/Therapy	Doctor/Provider	Approx. Date of Tx	Helpful (y/n)

☐ See attached list

History of Symptoms

On what date, or approximate date, did the condition you are seeking treatment for occur? _____

Are any of the conditions listed or was your chief complaint caused by a motor vehicle accident? ☐Yes ☐No

If yes, what conditions: _____ Date of accident: _____

Does any family member have a sleep breathing disorder? ☐Yes ☐No If yes, explain: _____

_____

Has your child had any of the following:

Orthodontic Treatment?	☐Yes ☐No	
Stopped breathing during sleep?	☐Yes ☐No	
Sleep Study?	☐Yes ☐No	
☐HST (Home Sleep Test) ☐PSG (Polysomnogram in Sleep Lab) Date: _____ Result: _____		
Positive Airway Pressure Devices Used?	☐CPAP ☐BiPAP ☐ASV ☐APAP	
Orthodontic Appliance?	☐Yes ☐No	Type: _____
Myofunctional Therapy?	☐Yes ☐No	Type: _____
Other Therapy?	☐Yes ☐No	Type: _____
Breastfed	☐Yes ☐No	Until what age? _____
Bottle fed	☐Yes ☐No	Until what age? _____
Pacifier	☐Yes ☐No	Until what age? _____
Thumb or Finger Habit	☐Yes ☐No	Until what age? _____

Other_____

Medical History

AIDS/HIV	☐ Yes ☐No
Anemia	☐ Yes ☐No ☐Fam Hx
Anxiety	☐ Yes ☐No ☐Fam Hx

Patient/Parent Signature: _____ Date: _____

Asthma ☐ Yes ☐No ☐Fam Hx
Bleeding Easily ☐ Yes ☐No ☐Fam Hx
Birth Defects ☐ Yes ☐No ☐Fam Hx
Bruising Easily ☐ Yes ☐No ☐Fam Hx
Cancer of _____ ☐ Yes ☐No ☐Fam Hx
Chemo ☐ Yes ☐No ☐Fam Hx
Chronic Fatigue ☐ Yes ☐No ☐Fam Hx
Cold Hands and Feet ☐ Yes ☐No ☐Fam Hx
COPD ☐ Yes☐No☐Fam Hx
Depression ☐ Yes☐No☐Fam Hx
Diabetes ☐ Yes☐No☐Fam Hx
Difficulty Concentrating ☐ Yes ☐No ☐Fam Hx
Difficulty Breathing at Night ☐ Yes ☐No ☐Fam Hx
Dizziness ☐ Yes ☐No ☐Fam Hx
Eating Disorder ☐ Yes ☐No ☐Fam Hx
(EDS) Ehlers-Danlos Syndrome ☐ Yes ☐No ☐Fam Hx
Emphysema ☐ Yes ☐No ☐Fam Hx
Epilepsy ☐ Yes ☐No ☐Fam Hx
Excessive Thirst ☐ Yes ☐No ☐Fam Hx
Fainting ☐ Yes ☐No ☐Fam Hx
Fibromyalgia ☐ Yes ☐No ☐Fam Hx
Fluid Retention ☐ Yes ☐No ☐Fam Hx
Frequent Colds/Flu ☐ Yes ☐No ☐Fam Hx
Frequent Cough ☐ Yes ☐No ☐Fam Hx
Frequent Ear Infections ☐ Yes ☐No ☐Fam Hx
Frequent Sore Throat ☐ Yes ☐No ☐Fam Hx
Awakening from Sleep ____ x ☐ Yes ☐No ☐Fam Hx
Gastroesophogeal Reflux ☐ Yes ☐No ☐Fam Hx
Glaucoma ☐ Yes ☐No ☐Fam Hx
Hay Fever ☐ Yes ☐No ☐Fam Hx
Hearing Impairment ☐ Yes ☐No ☐Fam Hx
Heart Attack ☐ Yes ☐No ☐Fam Hx
Heart Disease ☐ Yes☐No☐Fam Hx
Heart Murmur ☐ Yes ☐No ☐Fam Hx
Heart Pacemaker ☐ Yes ☐No ☐Fam Hx
Heart Palpitations ☐ Yes ☐No ☐Fam Hx
Heart Valve Replacement ☐ Yes ☐No ☐Fam Hx
Hemophilia ☐ Yes ☐No ☐Fam Hx
Hepatitis ☐ Yes ☐No ☐Fam Hx
High Blood Pressure ☐ Yes ☐No☐Fam Hx

History of Substance Abuse ☐ Yes ☐No ☐Fam Hx
Huntington's Disease ☐ Yes ☐No ☐Fam Hx

Hypoglycemia ☐ Yes ☐No ☐Fam Hx
Insomnia ☐ Yes ☐No ☐Fam Hx
Intestinal Disorder ☐ Yes ☐No ☐Fam Hx
Irregular Heartbeat ☐ Yes ☐No ☐Fam Hx
Kidney Disease ☐ Yes ☐No ☐Fam Hx
Leukemia ☐ Yes ☐No ☐Fam Hx
Liver Disease ☐ Yes ☐No ☐Fam Hx
Low Blood Pressure ☐ Yes ☐No ☐Fam Hx
Meniere's Disease ☐ Yes ☐No ☐Fam Hx
Memory Loss ☐ Yes ☐No ☐Fam Hx
Migraines ☐ Yes ☐No ☐Fam Hx
Mitral Valve Prolapse ☐ Yes ☐No ☐Fam Hx
Multiple Sclerosis ☐ Yes ☐No ☐Fam Hx
Muscle Aches ☐ Yes ☐No ☐Fam Hx
Muscle Fatigue ☐ Yes ☐No ☐Fam Hx
Muscle Spasms ☐ Yes ☐No ☐Fam Hx
Muscular Dystrophy ☐ Yes ☐No ☐Fam Hx
Neuralgia ☐ Yes ☐No ☐Fam Hx
Nervous system Disorder ☐ Yes ☐No ☐Fam Hx
Osteoarthritis ☐ Yes ☐No ☐Fam Hx
Osteoporosis ☐ Yes ☐No ☐Fam Hx
Ovarian Cyst ☐ Yes ☐No ☐Fam Hx
Parkinson's Disease ☐ Yes ☐No ☐Fam Hx
Poor Circulation ☐ Yes ☐No ☐Fam Hx
(POTS) Postural Orthostatic Tachycardia Syndrome ☐ Yes ☐No ☐Fam Hx
Psychiatric Care ☐ Yes ☐No ☐Fam Hx
Radiation ☐ Yes ☐No ☐Fam Hx
Recent Weight Gain ☐ Yes ☐No ☐Fam Hx
Recent Weight Loss ☐ Yes ☐No ☐Fam Hx
Rheumatic Fever ☐ Yes ☐No ☐Fam Hx
Rheumatoid Arthritis ☐ Yes ☐No ☐Fam Hx
Scarlet Fever ☐ Yes ☐No ☐Fam Hx
Shortness of Breath ☐ Yes ☐No ☐Fam Hx
Skin Disorder ☐ Yes ☐No ☐Fam Hx
Sinus Problems ☐ Yes ☐No ☐Fam Hx
Slow Healing Sores ☐ Yes ☐No ☐Fam Hx
Speech Difficulties ☐ Yes ☐No ☐Fam Hx
Stroke ☐ Yes ☐No ☐Fam Hx
Swollen or Painful Joints ☐ Yes ☐No ☐Fam Hx
Thyroid Disease ☐ Yes ☐No ☐Fam Hx
Tired Muscles ☐ Yes ☐No ☐Fam Hx
Tuberculosis ☐ Yes ☐No ☐Fam Hx
Urinary Tract Disorder ☐ Yes ☐No ☐Fam Hx
OTHER _____

I authorize the release of all examination findings and diagnosis, report and treatment plans, etc., to any referring or treating health care provider. I additionally authorize the release of any medical information to insurance companies, third party billing companies, or for legal documentation to process claims. I understand that I am responsible for all charges incurred for my treatment regardless of insurance coverage.

Patient/Parent Signature: _____ Date: _____

BEARS SLEEP SCREENING

The "BEARS" instrument is divided into five major sleep domains, providing a comprehensive screen for the major sleep disorders affecting children in the 2- to 18-year old range. Each sleep domain has a set of age-appropriate "trigger questions" for use in the clinical interview.

B = bedtime problems
E = excessive daytime sleepiness
A = awakenings during the night
R = regularity and duration of sleep
S = snoring

A parent answers questions in **black**, the subject child answers questions written in **blue**:

Symptom	Age Toddler/Preschool (2-5 years)	Age School Age (6-12 years)	Age Adolescent (13-18 years)
1. Bedtime Problems	Does your child have any problems going to bed? Y N	Does your child have any problems at bedtime? (P) Y N Do you have any problems going to bed? (C)	Do you have any problems falling asleep at bedtime? (C) Y N
2. Excessive Daytime Sleepiness	Does your child seem overtired or sleepy a lot during the day? Y N	Does your child have difficulty waking in the morning, seem sleepy during the day or take naps? (P) Y N Do you feel tired a lot? (C) Y N	Do you feel sleepy a lot during the day? Y N In School? Y N While Driving? (C) Y N
3. Awakenings during the night	Does your child wake up a lot at night? (P) Y N	Does your child seem to wake up a lot at night? Y N Any sleepwalking or nightmares? (P) Y N Do you wake up a lot at night? Y N Have trouble getting back to sleep? (C) Y N	Do you wake up a lot at night? Y N Have trouble getting back to sleep? (C) Y N
4. Regularity and duration of sleep	Does your child have a regular bedtime and wake time? Y N What are they? _____	What time does your child go to bed and get up on school days? _____ _____ Weekends? _____ Do you think he/she is getting enough sleep? (P) Y N	What time do you usually go to bed on school nights? _____ _____ Weekends? _____ How much sleep do you usually get? (C) _____
5. Snoring	Does your child snore a lot or have difficult breathing at night? Y N	Does your child have loud or nightly snoring or any breathing difficulties at night? (P) Y N	Does your teenager snore loudly or nightly? (P) Y N

(P) Parent-directed question
(C) Child-directed question

Source: "A Clinical Guide to Pediatric Sleep: Diagnosis and Management of Sleep Problems" by Jodi A. Mindell and Judith A. Owens; Lippincott Williams & Wilkins

Patient/Parent Signature: _____ Date: _____

PEDIATRIC SLEEP QUESTIONNAIRE (PSQ)

1. While sleeping does your child….

Snore more than half the time?	☐ Yes	☐No
Always snore?	☐ Yes	☐No
Snore loudly?	☐ Yes	☐No
Have "heavy" or loud breathing	☐ Yes	☐No
Have trouble breathing or struggle to breathe	☐ Yes	☐No
Have you ever seen your child stop breathing during the night?	☐ Yes	☐No

2. Does your child…..

Tend to breathe through the mouth during the day?	☐ Yes	☐No
Have a dry mouth on waking up in the morning?	☐ Yes	☐No
Occasionally wet the bed?	☐ Yes	☐No
Wake up feeling unrefreshed in the morning?	☐ Yes	☐No
Have a problem with sleepiness during the day?	☐ Yes	☐No
Have a teacher or other supervisor comment that your child appears sleepy during the day?	☐ Yes	☐No
Find it hard to wake your child up in the morning?	☐ Yes	☐No

3. Did your child stop growing at a normal rate at any time since birth? ☐ Yes ☐No

4. Is your child overweight? ☐ Yes ☐No

5. This child often…..

Does not seem to listen when spoken to directly.	☐ Yes	☐No
Has difficulty organizing tasks and activities.	☐ Yes	☐No
Is easily distracted by extraneous stimuli.	☐ Yes	☐No
Fidgets with hands or feet or squirms in seat.	☐ Yes	☐No
Is "on the go" or often acts as if "driven by a motor".	☐ Yes	☐No
Interrupts or intrudes on others (butts into conversations or games)	☐ Yes	☐No

Patient/Parent Signature: _____ Date: _____