## CHILDREN UNDER 21

Addendum to health history for pediatric patients:

Name_____ Age____ Ht:__ft___in Wt:_____lbs

Date:_____

Name of person filling out this form_____

Relationship to the child_____

1. Does your child have difficulty falling asleep at the beginning of the night? YES/NO
2. Does your child have difficulty staying asleep throughout the night? YES/NO
3. Is it difficult to wake up your child? YES/NO
4. Does your child experience cramps or pains in their legs or feet while laying in bed? YES/NO
5. Does your child kick or twitch their legs while sleeping? YES/NO
6. Does your child snore at night? YES/NO
7. Does your child have pauses in breathing or gasping sounds during sleep? YES/NO
8. Does your child have unusual behaviors (sleep walking, talking, nightmares, etc.) during sleep? YES/NO
9. Does your child have difficulty maintaining concentration during the day? YES/NO
10. Is your child hyperactive during the day (has difficulty sitting still)? YES/NO
11. Has your child been diagnosed with ADD or ADHD? YES/NO
12. If yes, to the above then is your child on any medication(s) for this? YES/NO
13. Does your child have problems with being sleepy during the day? YES/NO
14. Does your child wake up with dry mouth, headaches, aching in the jaw joint, drooling on the pillow, heartburn, chest pain, excessive sweating, bedwetting or nasal congestion on awakening? YES/NO
15. Has your child been diagnosed with large tonsils? YES/NO

Total Yes: _____ Total No: _____