The Connecticut Center for Sleep Medicine
Pediatric Fast Track Clinical Form
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Name **Age** **Sex** **Primary MD** **Consult Req from:**

History of Present Illness Date

Questions	**Yes/No or best guess**	**Doctors Comments Only**
1. What time is bedtime? Weekdays? Weekends?		
2. What time is "out-of bed time"? Weekdays? Weekends?		
3. What are the approximate times for meals and/or bottles?		
4. How long does it take for the child to fall asleep?		
5. How many times does the child wake at night?		
6. How long does the child stay awake each time you get up at night?		
7. Does the child take naps?		
8. What time are the naps?		
9. In a 24-hr period how many hours does the child spend in bed?		
10. In a 24-hr period how many hours does the sleep?		
11. Is the child's bedroom quiet and comfortable?		
12. Does the child have her/his own room?		
13. Is there a computer, TV or radio in the room?		
14. Does the child snore?		
15. Does the child make choking sounds?		
16. Does the child stop breathing at night?		
17. Does the child work hard to breath?		
18. Does the child move a lot while sleeping?		
19. Does the child walk in her sleep?		
20. Does the child wake up screaming at night?		
21. Is bed wetting a problem?		
22. Does the child appear sleepy in the morning or during the day?		
23. Has the child ever become suddenly weak during laughing or other emotional times?		
24. Has the child ever complained about seeing things when going to sleep or waking?		
25. Has the child ever complained about not being able to move when going to sleep or waking?		

26. Has the child had problems in school or day care?		
27. Has the child had behavioral problems at home?		
28. Does the child drink any caffeine containing beverages (for example Coke, Ice Tea, Root Beer)?		
29. Does anyone smoke in the house?		
30. How long has the problem been going on?		
31. Has the child ever had a sleep study before?		

Please list any medications including herbal preparations and vitamins

Please list any illnesses or surgeries that the child has had:

Please list any allergies including medication, food or seasonal:

Has the child had any of these problems (circle those that apply):

Weight Change	Developmental problems
Learning Disabilities	Small for Age
Nasal Congestion	Large for Age
Difficulty Playing with Others	ADD

Check if physical exam is listed in Referring MD's note ☐

Physician Notes

History reviewed by _____MD **Height:**

***Note, sleep tests should not be ordered until this is signed** **Weight:**