MADISON MEMORIAL HOSPITAL

New Patient Pediatric Comprehensive Intake Form—Sleep Clinic

Name: _____ **Date of Birth:** _____ **Date**:_____

Section 1: ID Risk Screen

☐ No Travel History ☐ Last 7 Days ☐ Last 14 Days ☐ Last 21 Days ☐ Last 2 Months

Recent Travel Location: _____

Family Member/Household/Contact Travel History

☐ No Travel History ☐ Last 7 Days ☐ Last 14 Days ☐ Last 21 Days ☐ Last 2 Months

Recent Travel Location: _____

*Contact with person with highly contagious disease (Ebola/MERS/2019-nCoV) AND have one or more of the systems below: ☐ Yes ☐ No

*Travel to a country with wide-spread (Ebola/MERS/2019-nCoV) in the past 21 days AND have one or more of the systems below: ☐ Yes ☐ No

Ebola Symptoms: Fever, Headache, Weakness, Muscle Pain, Vomiting, diarrhea, Abdominal Pain or Hemorrhage

MERS (Middle East Respiratory Syndrome) Symptoms: Fever, Chills/Rigors, Headache, Sore Throat, Cough, Difficulty Breathing, Nausea, Vomiting, Diarrhea, Abdominal Pain or Muscle Pain
Zika Symptoms: Macular or Papular Rash, Fever, Arthralgia or Conjunctivitis
Some symptoms are not unique for TB. For new or worsening cough, provide patient with a mask.
2019-nCov (2019-nCoV Novel Coronavirus) Symptoms: Fever and symptoms of lower respiratory illness (e.g., cough, difficulty breathing)
Infectious Disease Risk Factors/Symptoms—*(Only if YOU or FAMILY MEMBER has traveled)*

	Yes	No
Chills		
Fever		
Fatigue		
Headache		
Runny or Stuffy Nose		
Sore Throat		
Difficulty Breathing		
Shortness of Breath		
New or Worsening Cough		
Wheezing		

	Yes	No
Vomiting		
Diarrhea		
Abdominal(Stomach Pain)		
Weakness/Numbness		
Exposure to Disease		
Abnormal Breathing		
Unexplained bruising		
Joint Pain		
Abscess		
Rash		

MDRO History Surveillance

	Yes	No
History of Clostridium Difficile		
History of Extended Spectrum beta-Lactamase		
History of MRSA		
History of Vancomycin-resistant enterococci		
History of Carbapenem-resistant Enterobacteriaceae		
Other		

Verify droplet, Contact Isolation for Ebola: ☐ Yes ☐ N/A

*Verify Airborne, Contact Isolation for MERS/2019-CoV: ☐ Yes ☐ N/A

Does the patient have any of the following conditions that compromise the immune system?

○ None	○ Myelogenic Leukemia within 90 days
○ Acquired immune deficiency syndrome (AIDS)	○ Organ Transplant
○ AIDS related complex (ARC)	○ Pancytopenia within 90 days
○ Any immunodeficiency syndrome	○ Prior hospitalization within 14 days
○ Chronic Lymphocytic Leukemia (CLL)	○ Radiation therapy within 90 days
○ Congenital or hereditary immunodeficiency	○ Significant neutropenia within 90 days
○ Human Immunodeficiency Virus (HIV)	○ Systemic chemotherapy within 90 days
○ Leukemia within 90 days	○ Systemic corticosteroid/Prednisone therapy within 90 days
○ Lymphocytic Leukemia within 90 days	
○ Marked Neutropenia within 90 days	○ Systemic immunosuppressive therapy within 90 days
○ Myelodysplasia within 90 days	

Section 2: Summary

Chief Complaint: _____

Neck Circumference: _____inches

Onset of Symptoms: _____

Additional Information: _____

Preferred Language: _____ Method of Arrival: _____

Arrived With: _____ Consent Signed: _____

Onset of Symptoms: _____ Last Menstrual Period: _____

Vitals:

BP: _____ BP site: _____ HR: _____ HR Site: _____

Temp: _____ Site: _____ RR: _____ SpO2 %: _____ O2: _____

Measurements:

Height: _____in/cm Weight: _____lb/kg Method Weight Obtained: _____

Head Circumference: _____cm Abdominal Circumference: _____cm
Chest Circumference: _____ cm

Section 3: Problems and Visit Diagnosis

Diagnosis: Why are you being seen today?

_____

Past Medical History:

Date	Problem

Section 4: Medications/Allergies

Please list **medications** (including supplements) you are taking now, as well as the **dose** and **date** you started taking it (if known):

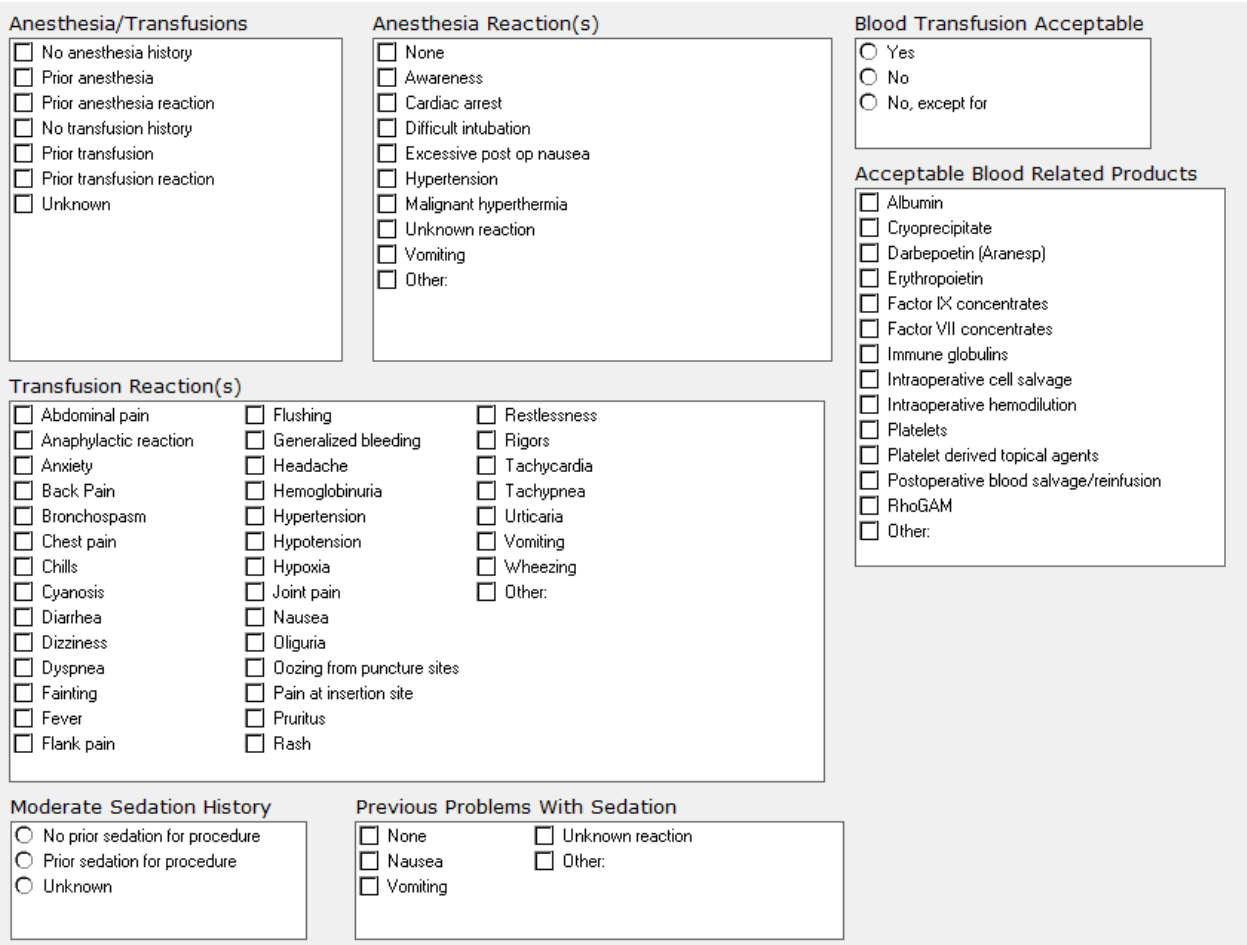
Medication Name	Dose (amount taking)	Start Date

Please list any known **allergies** you have, as well as the **type of reaction**:

Allergy	Type of Reaction
Do You have a Latex (rubber) allergy?	☐ Yes ☐ No

Section 5: Procedures/Surgeries

Anesthesia and Transfusions:



Section 6: Family History

Relationship:	Mother	Father	Sister	Brother	Grandparent
Health Status:					
Cardiovascular:					
Aneurysm					
Heart attack					
High blood pressure					
Endocrine/Metabolic:					
Diabetes Mellitus Type I					
Diabetes Mellitus Type II					
Thyroid Disease					
Eye:					
Cataract					
Glaucoma					
Gastrointestinal:					
GERD-Gastro-esophageal reflux disease					
Hiatal Hernia					
Irritable bowel syndrome					
Liver disease					
Peptic ulcer disease					
Genitourinary:					
Enlarged prostate					
Incontinence					
Kidney disease					
Prostate cancer					
Hematologic:					
Bleeding disorder					
Hemophilia					
Immunologic:					
AIDS					
Autoimmune disease					
Musculoskeletal:					
Acute arthritis					
Back Injury					
Back Pain					
Fibromyalgia					
Osteoporosis					
Rheumatism					
Neurologic:					
Alzheimer's Disease					
Migraine					
Seizure					
Stroke					
TIA					
Tremor					

Oncological:	Mother	Father	Sister	Brother	Grandparent
Bladder Cancer					
Bone Tumor					
Brain Tumor					
Breast Cancer					
Colon Cancer					
Prostate Cancer					
Uterus Cancer					
Lung Cancer					
Cervix Cancer					
Ovary Cancer					
Hodgkin's Disease					
Leukemia					
Lymphoma					
Non-Hodgkin's Lymphoma					
Skin Cancer					
Psychiatric:					
Addiction					
Alcohol Abuse					
Anxiety					
Bipolar Disorder					
Dementia					
Depression					
Schizophrenia					
Suicidal thoughts					
Respiratory:					
Asthma					
COPD					
Sleep Apnea					
Genetic:					
Celiac Disease					
Cystic Fibrosis					
Down's Syndrome					
Muscular dystrophy					
Exposures:					
Alcohol User					
Substance User					
Tobacco User					
OTHER:					

Section 7: Social History

Have you been hospitalized outside the US in past 6 months? ☐ Yes ☐ No

Patient shows signs/symptoms of neglect? ☐ Yes ☐ No

History Assessed: ☐ Yes ☐ No

Have you used Tobacco anytime during the past 30 days? ☐ Yes ☐ No

Alcohol Use: ☐ Current ☐ Past ☐ Never

Type: ☐ Beer ☐ Wine ☐ Liquor ☐ Other:

Frequency: ☐ 1-2 x year ☐ 1-2 x month ☐ 1-2 x week ☐ 3-5 x week ☐ Daily ☐ Several x Day

Tobacco Use:

☐ Current Status unknown ☐ Unknown if ever smoked ☐ Current every day smoker

☐ Current some day smoker ☐ Former smoker ☐ Never smoker

☐ Heavy tobacco smoker ☐ Light tobacco smoker

Electronic Cigarette Use:

☐ Never ☐ Use, within 90 days ☐ Former use, greater than 90 days

☐ Refused screening ☐ Unknown/Not Obtained ☐ Other

Type: _____ Uses/Inhales per day: _____

Substance Use: ☐ Current ☐ Past ☐ Never

Type: _____

Caffeine Use: ☐ Yes ☐ No

Type: _____ Caffeine per day: _____

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Other: _____

Number of Children: _____

Living Arrangements:

☐ Alone ☐ Family/Significant Other ☐ Assisted Living ☐ Other: _____

Do you have daily help needed for self-care? ☐ Yes ☐ No ☐ Name of Caregiver:_____

Activities of Daily Living: Any difficulty with? Speech or Communication Memory

☐ Speech or Communication ☐ Memory ☐ Bathing ☐ Household Duties

Physical Activity: Exercise Type: _____ Frequency: _____

Section 8: Morse Fall Risk

History of Falling Immediate or Within Last 3 Months: ☐ Yes ☐ No

Presence of Secondary Diagnosis: ☐ Yes ☐ No

Use of Ambulatory Aid: ☐ Furniture ☐ Crutches, cane, walker ☐ None, bedrest, wheelchair

IV/Heparin Lock: ☐ Yes ☐ No

Gait/Transferring: ☐ Impaired ☐ Weak ☐ Normal, bedrest, immobile

Mental Status: ☐ Forgets Limitations ☐ Oriented to own ability

Section 9: Advance Directives

Advance Directives: ☐ Yes ☐ No

Patient Wishes to Receive Further Information on Advance Directives: ☐ Yes ☐ No

Section 10: Health Status

Allergies Verified	Meds Verified	History Verified
○ Yes ○ No	○ Yes ○ No	○ Yes ○ No

Immunizations Current: ☐ Yes ☐ No ☐ Non Received ☐ Unknown ☐ Vaccine Recommended

☐ Other

Patient Counseled

- ☐ Nutrition
- ☐ Other:
- ☐ Physical activity
- ☐ Elevated BMI

Medical Devices

- ☐ None
- ☐ Pacemaker
- ☐ Implantable cardioverter-defibrillator
- ☐ Other:
- ☐ Insulin pump
- ☐ Medication pump

Durable Medical Equipment

- ☐ Oxygen therapy
- ☐ Commode
- ☐ Immobilizer
- ☐ Walker
- ☐ CPAP
- ☐ Other:
- ☐ Wheelchair
- ☐ Spirometry
- ☐ Bed
- ☐ Splint

Section 11: Pediatric Depression Screening

Complete if 12 years or younger

PHQ2-PHQ9 Screening:

Over the past 2 weeks, how often have you been bothered by any of the following problems?	Not At All	Several Days	More than ½ the Days	Nearly Every Day
1. Little interest or pleasure in doing things:	0	1	2	3
2. Feeling down, depressed or hopeless:	0	1	2	3
If you answered 0 to the questions above- stop				
3. Trouble falling asleep, staying asleep or sleeping too much:	0	1	2	3
4. Feeling tired or having little energy:	0	1	2	3
5. Poor appetite or overeating:	0	1	2	3
6. Feeling bad about yourself:	0	1	2	3
7. Trouble concentrating:	0	1	2	3
8. Moving or speaking so slowly:	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way:	0	1	2	3
10. Difficulty at work, home, or getting along with others:	0	1	2	3
Column Totals:				
Add Totals Together:				

11. If you checked off any problems, how difficult have those problems made it for you to do your work, take care of things at home, or get along with other people?

☐ Not Difficult at all ☐ Somewhat Difficult

☐ Very Difficult ☐ Extremely Difficult

Pediatric Questionnaire - Sleep Clinic

Please completely fill in the circles which best describe your current condition. Please answer all questions. Thank you

Pulmonary:	Yes	No
Shortness of breath at rest	O	O
Shortness of breath with exercise	O	O
Frequent cough	O	O
Coughing up blood	O	O
Chest pain	O	O
Wake up at night short of breath	O	O
Recurrent chest infections	O	O
Exposure to tuberculosis	O	O
Wheezing	O	O
Blood clot in legs or lungs	O	O
Cardiac:		
High blood pressure	O	O
Heart attack	O	O
Leg swelling	O	O
Heart racing or thumping	O	O
Rheumatic fever	O	O
Needs to sleep on 2 or more pillows	O	O
High cholesterol	O	O
Constitutional symptoms:		
Fever	O	O
Night sweats	O	O
Chills	O	O
Weight loss	O	O
Musculoskeletal:		
Muscle weakness	O	O
Joint pain	O	O
Joint swelling	O	O
Psychiatric:		
Depression	O	O
Anxiety	O	O
Poor sleep	O	O
Snoring	O	O
Morning headaches or awakening	O	O
Excessive sleep during day	O	O
Panic attacks	O	O

Gastrointestinal:	Yes	No
Trouble swallowing	O	O
Choking on food	O	O
Heartburn	O	O
Abdominal pain	O	O
Nausea	O	O
Vomiting	O	O
Diarrhea	O	O
Ulcers	O	O
Jaundice	O	O
Renal:		
Blood in urine	O	O
Urinary tract infections	O	O
Kidney stones	O	O
Frequent urination at night	O	O
Painful urination	O	O
Neurologic:		
Stroke	O	O
Migraines	O	O
Frequent headaches	O	O
Numbness or tingling	O	O
Seizure	O	O
Dizziness	O	O
Imbalance or unsteadiness	O	O
Vertigo	O	O
Hematology/Oncologic:		
Anemia	O	O
Cancer	O	O
Bleeding tendency	O	O
Blood transfusion	O	O
ENT:		
Blurred vision	O	O
Decreased hearing	O	O
Frequent sore throat	O	O
Sinus infections	O	O
Hay fever	O	O
Hoarseness	O	O

PEDIATRIC SLEEP HISTORY

This questionnaire will provide the Sleep Disorders Program with a better understanding about your child's case. Please answer all questions to the best of your ability. If any questions are not applicable please leave them blank.

1. Child's usual bedtime on weeknights: _____am/pm
2. Child's usual wake time on weekdays: _____am/pm
3. Child's usual bedtime on weekends: _____am/pm
4. Child's usual wake time on weekends: _____am/pm
5. On average, how many hours does your child sleep per night? _____hours
6. How long does it usually take your child to fall asleep? _____minutes
7. Under usual circumstances, how often does your child awaken during the night: _____times per night
8. Does your child return to sleep without assistance after waking at night? yes/no
9. Does your child awaken too early and have difficulty going back to sleep? yes/no
   If "yes" estimate how many times per week: _____times per week
10. Does your child fall asleep alone in his/her own bed? yes/no
11. Does your child need someone in the room to fall asleep? yes/no
12. Does your child need a special object to fall asleep? yes/no
13. Does your child go to bed without a struggle? yes/no
14. Is your child afraid to sleep in the dark? yes/no
15. How long has your child experienced sleep problems? _____months
16. Does your child snore? yes/no
    If "yes" estimate how long: _____months
17. Does your child grind his/her teeth during sleep? yes/no
    If "yes" estimate how long: _____months
18. Does your child get up in the night to use the restroom? yes/no
19. Does your child stop breathing during sleep? yes/no
20. Does your child complain of awakening with a sensation of choking during the night? yes/no
21. Does your child breath with his/her mouth open while sleeping? yes/no

22. Does your child's arms and legs jerk during sleep? yes/no

23. Does your child sleep walk? yes/no

24. Does your child talk during sleep? yes/no

25. Does your child complain of body pain during sleep? yes/no
    If "yes" what type? _____type

26. Does your child usually seem rested when he/she wakes up? yes/no

27. Does your child usually wake up by him/herself? yes/no

28. Does your child have difficulty getting up in the morning? yes/no

29. How long does it usually take for your child to become alert in the morning? _____minutes

30. Does your child feel sleepy during the day? yes/no

31. How long has daytime sleepiness been a problem for your child? _____months

32. Does your child usually take naps during the day? yes/no

33. Does your child usually seem tired? yes/no

34. Does sleepiness interfere with your child's normal work/school performance?
    (Include his/her job and/or home activities) yes/no

35. Does sleepiness interfere with your child's normal social activities with family, friends, or other groups? yes/no

36. Has your child had accidents or near accidents because of sleepiness? yes/no

37. Have you ever been told that a family member has a sleep disorder? yes/no
    Type of sleep disorder:_____

38. When your child is angry, laughing, or frightened, does he/she complain of feeling weak as though he/she might fall? yes/no

39. Does your child remember dreams? yes/no

40. Does your child have nightmares? yes/no
    If "yes" estimate how many per week: _____per week

41. Does your child ever wake up screaming/yelling from a nightmare? yes/no
    If "yes" estimate how many times per week: _____per week

42. When your child falls asleep or just before he/she wakes up does he/she:

    a. Have bizarre dreams? yes/no
    b. Feel as if he/she is paralyzed? yes/no

43. Does your child have difficulty concentrating? yes/no
44. Has your child recently had problems with memory/attention to detail? yes/no
45. Have you noticed a difference in your child's personality in the last six months? yes/no
46. Does your child feel stressed? yes/no
47. Does your child experience anxiety? yes/no
48. Does your child ever seem irritable? yes/no
49. Has your child recently felt depressed? yes/no
50. Does your child have any behavioral problems? yes/no
51. Does your child have headaches? yes/no
52. Does your child have any allergies? yes/no
53. Has your child been diagnosed with ADHD/ADD yes/no
54. Does your child have speech problems? yes/no
55. Does your child have difficulty swallowing? yes/no
56. Has your child had his/her tonsils removed? yes/no
57. Does your child have thyroid disease? yes/no
58. Does your child have asthma? yes/no
59. Does your child have diabetes? yes/no
60. Does your child have difficulty breathing? yes/no
61. Does your child have any nasal/sinus problems? yes/no
62. Has your child ever had surgery on his/her sinuses for a sleep disorder? yes/no
63. Does your child have heartburn (acid reflux)? yes/no
64. Does your child have any neurological disorders? yes/no
65. Does your child have any neuromuscular diseases? yes/no
66. Does your child have a history of seizures? yes/no
67. Has your child had a traumatic brain injury/concussion? yes/no
68. Has your child had a spinal cord/neck injury? yes/no

69. Does your child wet the bed? yes/no

70. Does your child have any facial abnormalities? yes/no

71. Does your child drink caffeinated beverages? yes/no
    If "yes" estimate how many glasses, cups, or cans per day: _____per day

72. Has your child previously been diagnosed with a sleep disorder? yes/no

73. Has your child ever had surgery, taken medications, or received other treatment for sleep-related problems in the past? yes/no

IF "YES" PLEASE ANSWER QUESTIONS 77-80

IF "NO" PLEASE SKIP TO QUESTION 81

74. Is your child taking medications for his/her sleep problems? yes/no
    If "yes" please list_____
    _____

75. Does your child ever use an oxygen aid while sleeping? yes/no

76. Does your child use nasal CPAP or BIPAP for sleep apnea? yes/no

77. If "yes" does he/she feel any different when using CPAP or BIPAP? yes/no
    If "yes" in what way?_____

78. Do you have any major concerns regarding your child's physical or emotional well-being or overall health due to sleep problems? yes/no

79. Does your child enjoy sleep? yes/no

80. Does he/she like to sleep late whenever he/she can? yes/no

Please use the following space to comment on anything else you would like us to know about your child's medical or sleep problems. _____
_____
_____
_____