



**Infant Sleep Questionnaire  
(0-12 months of age)**

Patient's Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Date: \_\_\_\_\_

Person completing questionnaire  mother  father  grandparent  other \_\_\_\_\_

Please describe your child's sleep problem(s): \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

How long has this been a problem? \_\_\_\_\_ Has the problem become worse? \_\_\_\_\_

What do you think is causing the sleep problem? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

What have you previously tried to help this problem? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**Infant Schedule:**

Where does your infant sleep?  infant crib in a separate room  infant crib (bassinet) in parents' room  
 in parents' bed  infant crib in room with sibling  other \_\_\_\_\_

Does your infant sleep better on his/her  left side  right side  back  stomach

Does your infant sleep with  pacifier  blanket  stuffed toy  other \_\_\_\_\_

Does your infant sleep better in  silence  normal noise

Does your infant have trouble falling asleep?  yes  no

Is there a regular bedtime routine?  yes  no

Does your infant fall asleep  while feeding  being rocked  being held  in crib alone  
 in bed near parent  other \_\_\_\_\_

Does your infant awaken during the night (other than feedings)?  Yes  No

If so, does your child have difficulty returning to sleep?  Yes  No

Does your infant tend to snore?  yes  no

Does your infant wake on his/her own or do you wake them? \_\_\_\_\_

Your infant eats breakfast at:  home  center at \_\_\_\_\_ o'clock

Diet  breast milk  formula – type \_\_\_\_\_  whole milk  juice

solid foods

Schedule of sleeping and eating – please specify sleep, wake and feeding/ meal times

6:00am \_\_\_\_\_

6:00pm \_\_\_\_\_

6:30am \_\_\_\_\_

6:30pm \_\_\_\_\_

7:00am \_\_\_\_\_

7:00pm \_\_\_\_\_

7:30am \_\_\_\_\_

7:30pm \_\_\_\_\_

8:00am \_\_\_\_\_

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11:00am \_\_\_\_\_

11:00pm \_\_\_\_\_

11:30am \_\_\_\_\_

11:30pm \_\_\_\_\_

12:00pm (noon) \_\_\_\_\_

12:00am (midnight) \_\_\_\_\_

12:30pm \_\_\_\_\_

12:30am \_\_\_\_\_

1:00pm \_\_\_\_\_

1:00am \_\_\_\_\_

1:30pm \_\_\_\_\_

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4:30am \_\_\_\_\_

5:00pm \_\_\_\_\_

5:00am \_\_\_\_\_

5:30pm \_\_\_\_\_

5:30am \_\_\_\_\_

**Current Sleep Symptoms:**

Difficulty breathing when asleep?	<input type="checkbox"/> Never	<input type="checkbox"/> Occasionally	<input type="checkbox"/> Frequently
Stops breathing during sleep?	<input type="checkbox"/> Never	<input type="checkbox"/> Occasionally	<input type="checkbox"/> Frequently
Snores?	<input type="checkbox"/> Never	<input type="checkbox"/> Occasionally	<input type="checkbox"/> Frequently
Sweating during sleep?	<input type="checkbox"/> Never	<input type="checkbox"/> Occasionally	<input type="checkbox"/> Frequently
Screaming during sleep?	<input type="checkbox"/> Never	<input type="checkbox"/> Occasionally	<input type="checkbox"/> Frequently
Legs or arms moving during sleep?	<input type="checkbox"/> Never	<input type="checkbox"/> Occasionally	<input type="checkbox"/> Frequently
Waking up during the night?	<input type="checkbox"/> Never	<input type="checkbox"/> Occasionally	<input type="checkbox"/> Frequently
Getting out of bed during the night?	<input type="checkbox"/> Never	<input type="checkbox"/> Occasionally	<input type="checkbox"/> Frequently
Resistance going to bed?	<input type="checkbox"/> Never	<input type="checkbox"/> Occasionally	<input type="checkbox"/> Frequently
Teeth grinding?	<input type="checkbox"/> Never	<input type="checkbox"/> Occasionally	<input type="checkbox"/> Frequently
Uncomfortable feelings or pains in legs?	<input type="checkbox"/> Never	<input type="checkbox"/> Occasionally	<input type="checkbox"/> Frequently
Rock their head or body from side to side?	<input type="checkbox"/> Never	<input type="checkbox"/> Occasionally	<input type="checkbox"/> Frequently

**Medical History:**

History of prematurity?  Yes (how many weeks gestation \_\_\_\_\_)  No

If so, did your infant stay in the NICU?  yes  no

On a ventilator?  yes  no

Drug allergies?

List allergies: \_\_\_\_\_

Food/ environmental allergies

List allergies: \_\_\_\_\_

Current medications: \_\_\_\_\_

\_\_\_\_\_

Current medical problems: \_\_\_\_\_

\_\_\_\_\_

Previous hospitalizations: \_\_\_\_\_

\_\_\_\_\_

Previous surgeries: \_\_\_\_\_

\_\_\_\_\_

**Developmental History:**

Is your infant

Holding his/her head up?	◇ yes	age _____	◇ no
Turning over?	◇ yes	age _____	◇ no
Sitting up?	◇ yes	age _____	◇ no
Pulling up to standing?	◇ yes	age _____	◇ no
Cruising (walking while holding on to something)?	◇ yes	age _____	◇ no
Crawling?	◇ yes	age _____	◇ no
Standing by self?	◇ yes	age _____	◇ no
Walking?	◇ yes	age _____	◇ no
Holding his/her own bottle?	◇ yes	age _____	◇ no
Drinking from a cup?	◇ yes	age _____	◇ no

**Family Sleep History:**

Does anyone in the family:

Have Obstructive Sleep Apnea?	◇ Yes	◇ No
Have Restless Leg Syndrome?	◇ Yes	◇ No
Have Narcolepsy?	◇ Yes	◇ No
Smoke?	◇ Yes	◇ No

Mother's Age: \_\_\_\_\_

Father's Age: \_\_\_\_\_

Siblings:

Sisters' (age): \_\_\_\_\_

Brothers' (age): \_\_\_\_\_

List any specific instructions or helpful hints to better meet your infant's needs.

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