PEDIATRIC SLEEP QUESTIONNAIRE

DISCLAIMER: This questionnaire is designed to screen for breathing and sleeping disorders that affect development of teeth, jaw structures and face.

SLEEPING AND BREATHING AT NIGHT

1. While sleeping, does your child ever snore? ❍ Yes ❍ No
2. While sleeping, does your child have "heavy" or loud breathing? ❍ Yes ❍ No
3. Have you ever seen your child stop breathing during night? ❍ Yes ❍ No
4. Does your child have restless sleep? ❍ Yes ❍ No
5. At night, does your child usually become sweaty? ❍ Yes ❍ No
6. At night, does your child usually get out of bed to urinate? ❍ Yes ❍ No
7. Does your child usually sleep with the mouth open? ❍ Yes ❍ No
8. Is your child's nose usually congested or “stuffed” at night? ❍ Yes ❍ No
9. Does your child get a burning feeling in the throat at night? ❍ Yes ❍ No
10. Do you hear your child grinding his or her teeth at night? ❍ Yes ❍ No
11. Does your child occasionally wet the bed? ❍ Yes ❍ No

BREATHING AND SLEEPINESS DURING THE DAY

1. Does your child tend to breathe through the mouth during the day? ❍ Yes ❍ No
2. Is it hard to wake your child up in the morning? ❍ Yes ❍ No
3. Does your child wake up with headaches? ❍ Yes ❍ No
4. Does your child have a dry mouth upon waking in the morning? ❍ Yes ❍ No
5. Does your child wake up feeling unrefreshed in the morning? ❍ Yes ❍ No
6. Does your child have a problem with sleepiness during the day? ❍ Yes ❍ No
7. Does your child usually take a nap during the day? ❍ Yes ❍ No

ALLERGIES AND OVERWEIGHT

1. Do any allergies affect your child's ability to breathe through the nose? ❍ Yes ❍ No
2. Did your child stop growing at a normal rate at any time since birth? ❍ Yes ❍ No
3. Is your child overweight? ❍ Yes ❍ No
4. Does you child have asthma and when was it first diagnosed? ❍ Yes ❍ No

SCHOOL PERFORMANCE

1. Does your child often have difficulty sustaining attention in tasks or play activities? ❍ Yes ❍ No
2. Does your child often have difficulty organizing tasks and activities? ❍ Yes ❍ No
3. Does your child often avoid, dislike or is reluctant to engage in tasks or activities that require concentration? ❍ Yes ❍ No
4. Does your child often forget in daily activities? ❍ Yes ❍ No
5. Does your child often fidget with hands or feet or squirm in his or her seat? ❍ Yes ❍ No
6. Does your child often have difficulty playing or engaging in leisure activities quietly? ❍ Yes ❍ No

PARENT OR GUARDIAN SIGNATURE

_____ _____

Patient/Parent/Guardian Signature Date