

Parent Name: _____
 City: _____ State: _____ Age: _____ Male or Female: _____
 Current Dentist: _____ Current Pediatrician: _____

Sleep Disordered Breathing Questionnaire for Children

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The initial column should be filled out at first appointment, and the follow up column should be completed after 3 months of treatment. Please identify the following symptoms your child exhibits with the scale indicating severity of symptoms.

0 – Not Present 1 – 2 Mild 3 Moderate 4 - 5 Pronounced

Does your child:

- | INITIAL | INITIAL |
|---|---|
| 1. _____ Snore at all? | 14. _____ Talks in sleep |
| 2. _____ Snore only infrequently (1 night/week) | 15. _____ Poor ability in school |
| 3. _____ Snore fairly often (2-4 nights/week) | 16. _____ Falls asleep watching TV |
| 4. _____ Snore habitually (5-7 nights/week) | 17. _____ Wakes up at night |
| 5. _____ Have labored, difficult, loud breathing at night | 18. _____ Attention deficit |
| 6. _____ Have interrupted snoring where breathing stops for 4 or more seconds | 19. _____ Restless sleep |
| 7. _____ Have stoppage of breathing more than 2 times in an hour | 20. _____ Grinds teeth |
| 8. _____ Hyperactive | 21. _____ Frequent throat infections |
| 9. _____ Mouth breathes during day | 22. _____ Feels sleepy and/or irritable during the day |
| 10. _____ Mouth breathes while sleeping | 23. _____ Have a hard time listening and often interrupts |
| 11. _____ Frequent headaches in morning | 24. _____ Fidgets with hands or does not sit quietly |
| 12. _____ Allergic symptoms | 25. _____ Ever wets the bed |
| 13. _____ Excessive sweating while asleep | 26. _____ Bluish color at night or during the day |
| | 27. _____ Speech Problems * |
- *If yes, provide parent speech questionnaire

Was your reason for coming to this doctor for sleep or dental issues: _____

Based on Sahin et al, 2009; and Urschitz et al, 2004; AM Thoracic Soc Stand, 1996; Attanasio et al, 2010

Speech Questionnaire

To be filled out only if #27 was indicated above

Please check all that apply to your child:

- | INITIAL | INITIAL |
|---|--|
| 28. _____ Is it difficult to understand your child's speech | 33. _____ Gets frustrated when people can't understand speech? |
| 29. _____ Difficult to understand over the phone? | 34. _____ Sometimes omits consonants |
| 30. _____ Nasal speech? | 35. _____ Uses M, N, NG instead of P, F, V, S, Z sounds |
| 31. _____ Speech sounds abnormal? | 36. _____ Hoarseness |
| 32. _____ Others have difficulty understanding speech? | 37. _____ Lisp |
| | 38. _____ Any speech therapy? |
| | How Long? _____ |