Parent Name: City: State: Age: Male or Female: Current Dentist: Current Pediatrician: Sleep Disordered Breathing Questionnaire for Children Earl O. Bergersen, DDS, MSD 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. O = Not Present	Patient Form		Mhoalthuctart		
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