

Doctor: _____

Child's Name _____ Age _____ Date: _____

Filled Out By: _____ Relationship to Patient: _____

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	FOLLOW UP		INITIAL	FOLLOW UP	
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	FOLLOW UP		INITIAL	FOLLOW UP	
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? _____