

Pediatric Sleep Questionnaire

Patient Name _____ Date _____

Please fill out this form as accurately and honestly as possible. In our practice, we are very interested in our patients' overall health. Orthodontic treatment can be an important part of managing the health problems caused by sleep and breathing disorders.

- ___ While sleeping, does your child snore more than half the time?
- ___ While sleeping, does your child always snore?
- ___ While sleeping, does your child snore loudly?
- ___ While sleeping, does your child have "heavy" or loud breathing?
- ___ While sleeping, does your child have trouble breathing, or struggle to breathe?
- ___ Have you even seen your child stop breathing during the night?
- ___ Does your child occasionally wet the bed, sleepwalk, or have night terrors (circle any)?
- ___ Does your child tend to breathe through the mouth during the day?
- ___ Does your child have a dry mouth on waking in the morning?
- ___ Does your child wake up unrefreshed in the morning?
- ___ Does your child wake up with headaches in the morning?
- ___ Is it hard to wake up your child in the morning?
- ___ Does your child have a problem with sleepiness during the day?
- ___ Has a teacher or supervisor commented - your child appears sleepy during the day?
- ___ Did your child stop growing at a normal rate at any time since birth?
- ___ Is your child overweight?
- ___ This child does not seem to listen when spoken to directly
- ___ This child often has difficulty organizing tasks and activities
- ___ This child often is easily distracted by extraneous stimuli
- ___ This child often fidgets with hands or feet, or squirms in seat
- ___ This child often is "on the go" or often acts as if "driven by a motor"
- ___ This child often interrupts or intrudes on others (butts in conversations or games)

Total Score = _____