

Doctor: _____

Child's Name _____ Age _____ Date: _____

Filled Out By: _____ Relationship to Patient: _____

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.

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 interrupt
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? _____

Based on Barr et al, 2007

© by Ortho-Tain[®] Inc. 2013 Printed in USA

Form 02221