



Pediatric Sleep Disordered Breathing Screening Questionnaire

Patient's Name: _____ Date: _____ Age: _____

Does Your Child:
1-3

Enter #

1. Mouth Breathe during the day?	1) Never	2) Sometimes	3) Often	_____
2. Mouth Breathe at night?	1) Never	2) Sometimes	3) Often	_____
3. Snore?	1) Never	2) Sometimes	3) Often	_____
4. Wet the Bed at night?	1) Never	2) Sometimes	3) Often	_____
5. Have Night Terrors?	1) Never	2) Sometimes	3) Often	_____
6. Grind their Teeth?	1) Never	2) Sometimes	3) Often	_____
7. Experience Restless Sleep?	1) Never	2) Sometimes	3) Often	_____
8. Wake up during the Night?	1) Never	2) Sometimes	3) Often	_____
9. Have Night Sweats ? (clothes/sheets are damp)	1) Never	2) Sometimes	3) Often	_____
10. Have Morning Headaches?	1) Never	2) Sometimes	3) Often	_____
11. Have Digestive Issues/ Stomach Aches _____	1) Never	2) Sometimes	3) Often	_____
12. Have Daytime Drowsiness?	1) Never	2) Sometimes	3) Often	_____
13. Seem to be Hyperactive? (can't sit still/fidgety)	1) Never	2) Sometimes	3) Often	_____
14. Struggle with Attention Issues?	1) Never	2) Sometimes	3) Often	_____
15. Struggle with Academics?	1) Never	2) Sometimes	3) Often	_____
16. Have any Speech Issues? *(note any speech therapy in comments)	1) Never	2) Sometimes	3) Often	_____
17. Have Ear, Nose, Throat Infections? *(note any surgery in comments)	1) Never	2) Sometimes	3) Often	_____



Home Observation Sheet

Check off what you see. If you're not sure, check it anyway. Make comments if you want.

While sitting around... (watching TV, in the car)

Does your child:

- ☐ Put "things" in the mouth a lot (toys, sleeves, pencils, fingernails, etc.)
- ☐ Lick or suck on their lips
- ☐ Have the lips apart, or even a little
- ☐ Stick or dart the tongue out of the mouth
- ☐ Have the tongue resting between the teeth
- ☐ Lean the cheek on a hand
- ☐ Breathe with his mouth open, even a little bit
- ☐ Make noises when breathing
- ☐ Have trouble sitting still

During a meal...

Does your child:

- ☐ Gasp for air while eating
- ☐ Stick his tongue between his teeth when swallowing
- ☐ Stick the tongue out to meet the drinking glass
- ☐ Drink a lot while eating
- ☐ Make noises when chewing
- ☐ Eat sloppily
- ☐ Take a breath before drinking
- ☐ Puff the cheeks out when drinking
- ☐ Make the lips purse when swallowing
- ☐ Make the chin "crinkle" when swallowing
- ☐ Bob the head when swallowing
- ☐ Have trouble sitting still
- ☐ Chew with mouth open
- ☐ Swallow with mouth closed

While sleeping

Does your child:

- ☐ Have trouble falling asleep
- ☐ Have the mouth open
- ☐ Snore
- ☐ Night Sweats
- ☐ Wet the bed
- ☐ Toss and turn – arm & leg movement
- ☐ Tilt the head back
- ☐ Wake up frequently
- ☐ Have frequent nightmares
- ☐ Have abnormal sleep issues
- ☐ Grind the teeth
- ☐ Have trouble waking up
- ☐ Wake with dark circles under eyes

While talking...

Does your child:

- ☐ Talk very fast
- ☐ Talk very slow
- ☐ Gasp for air
- ☐ Have lisp
- ☐ Take speech lessons

Medical history

Does your child have or complain of:

- ☐ Stomachaches
- ☐ Headaches
- ☐ Earaches
 - ☐ Ringing ears
 - ☐ Dizziness
 - ☐ Stuffy ears
 - ☐ Itchy ears
- ☐ Neck aches
- ☐ A runny nose
- ☐ A sore throat
- ☐ Trouble swallowing pills
- ☐ Dry or chapped lip
- ☐ Sore teeth or gums
- ☐ Sores in the mouth

As a baby was your child:

- ☐ Breastfed or bottle fed. Which? _____
- ☐ If breastfed, how long? _____
- ☐ Early to get teeth
- ☐ Late to get teeth
- ☐ Hard to feed
- ☐ Refusing to chew food
- ☐ Prone to ear infection

Did your child ever:

- ☐ Use a pacifier? Until age _____
- ☐ Suck a finger or thumb. Which? _____
- ☐ Have allergies
 - ☐ Food allergies
 - ☐ Skin allergies
 - ☐ Seasonal allergies
 - ☐ Take medication for allergies
- ☐ Have asthma
 - ☐ See a doctor about asthma
- ☐ Have learning problems
- ☐ Have attention problems
- ☐ "issues" at school

Did YOU (as the parent) ever:

- ☐ Have crowded teeth
- ☐ Have braces
- ☐ Have extractions for braces
- ☐ Have headgear
- ☐ Have asthma
- ☐ Have TMJ or jaw problems

Comments: