Pediatric Sleep Questionnaire

Patient Name: _____ Date: _____
Your doctor would like you to complete 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 breath?
____ Have you ever 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 up 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 your child up 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 often does not seem to listen when spoken to directly
____ This child often has difficulty organizing task 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 into conversations or games)

Total Score = _____

For our practice, Orthodontics is MUCH more than straight teeth

Ronald D. Chervin, et al *Arch Otolaryngol Head Neck Surg.* 2007;133(3):216-222