

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 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:

- |  |   |
|--|---|
| 1. _____ Is it difficult to understand your child's speech | 6. _____ Gets frustrated when people can't understand speech? |
| 2. _____ Difficult to understand over the phone?           | 7. _____ Sometimes omits consonants                           |
| 3. _____ Nasal speech?                                     | 8. _____ Uses M, N, NG instead of P, F, V, S, Z sounds        |
| 4. _____ Speech sounds abnormal?                           | 9. _____ Hoarseness   |
| 5. _____ Others have difficulty understanding speech?      | 10. _____ Lisp  |
|  | 11. _____ Any speech therapy?<br>How Long? _____              |