Pediatric Sleep Questionnaire

Patient Name: ______________________________ Date of Birth: __________

While sleeping does your child...	Yes	No	Don't Know
Snore more than half the time?			
Always snore?			
Snore loudly?			
Have heavy or loud breathing?			
Have trouble breathing/struggle to breathe?			
Have you ever...			
Seen your child stop breathing during sleep?			
Does your child...			
Tend to breathe through the mouth while awake?			
Have a dry mouth upon waking in the morning?			
Occasionally wet the bed?			
Wake up feeling un-refreshed in the morning?			
Have a problem with sleepiness during the day?			
Has a teacher or supervisor commented that your child appears sleepy during the day?			
Is it hard to wake your child in the morning?			
Does your child wake up with headaches?			
Did your child stop growing at a normal rate at any time since birth?			
Is your child overweight?			
My child often...			
Does not seem to listen when spoken to directly.			
Has difficulty organizing tasks.			
Is easily distracted by extraneous stimuli.			
Fidgets with hands/feet or squirms in seat.			
Is always "on the go" or often acts as if "driven by a motor."			
Frequently interrupts or intrudes on others (e.g. butts into conversations or games).			

Total number of "Yes" responses: ________

If eight or more statements are answered "yes," consider referring for sleep evaluation.

OVER→

Quality of Life Survey

Evaluation of Sleep-Disordered Breathing

For each question below, please circle the number that best describes how often each symptom or problem has occurred during the past 4 weeks (or since the last survey if sooner).

	None of the time	Hardly any of the time	A little of the time	Some of the time	A good bit of the time	Most of the time	All of the time
SLEEP DISTURBANCE							
During the past *4 weeks*, how often has your child had...							
...loud snoring?	1	2	3	4	5	6	7
...breath holding spells or pauses in breathing at night?	1	2	3	4	5	6	7
...choking or gasping sounds while asleep?	1	2	3	4	5	6	7
...restless sleep or frequent awakenings from sleep?	1	2	3	4	5	6	7
PHYSICAL SUFFERING							
During the past *4 weeks*, how often has your child had...							
...mouth breathing because of nasal obstruction?	1	2	3	4	5	6	7
...frequent colds or upper respiratory infections?	1	2	3	4	5	6	7
...nasal discharge or runny nose?	1	2	3	4	5	6	7
...difficulty in swallowing foods?	1	2	3	4	5	6	7
EMOTIONAL DISTRESS							
During the past *4 weeks*, how often has your child had...							
...mood swings or temper tantrums?	1	2	3	4	5	6	7
...aggressive or hyperactive behavior?	1	2	3	4	5	6	7
...discipline problems?	1	2	3	4	5	6	7
DAYTIME PROBLEMS							
During the past *4 weeks*, how often has your child had...							
...excessive daytime drowsiness or sleepiness?	1	2	3	4	5	6	7
...poor attention span or concentration?	1	2	3	4	5	6	7
...difficulty getting out of bed in the morning?	1	2	3	4	5	6	7
CAREGIVER CONCERNS							
During the past *4 weeks*, how often have the above problems...							
...caused you to worry about your child's general health?	1	2	3	4	5	6	7
...created concern that your child is not getting enough air?	1	2	3	4	5	6	7
...interfered with your ability to perform daily activities?	1	2	3	4	5	6	7
...made you frustrated?	1	2	3	4	5	6	7

OVERALL, HOW WOULD YOU RATE YOUR CHILD'S QUALITY OF LIFE AS A RESULT OF THE ABOVE PROBLEMS?
(Circle one number)