

PEDIATRIC SLEEP QUESTIONNAIRE
PATIENTS UNDER 18 YEARS OF AGE

PATIENT NAME:	DATE:
AGE:	

Please answer on behalf of your child for the past month.
If you do not know the answer to a question, circle the “?”

While sleeping, does your child...

1. snore more than half the time?.....Yes / No / ?
2. always snore?.....Yes / no / ?
3. snore loudly?.....Yes / No / ?
4. have trouble breathing or struggle to breathe?.....Yes / No / ?
5. have “heavy” or loud breathing?.....Yes / No / ?
6. Have you ever seen your child stop breathing during the night?.....Yes / No / ?

Does your child...

7. tend to breathe through the mouth during the day?.....Yes / No / ?
8. have a dry mouth on waking up in the morning?.....Yes / No / ?
9. occasionally wet the bed?.....Yes / No / ?
10. wake up feeling unrefreshed in the morning?.....Yes / No / ?
11. have a problem with sleepiness during the day?.....Yes / No / ?
12. has a teacher commented that your child appears sleepy during the day?.....Yes / No / ?
13. is it hard to wake your child up in the morning?.....Yes / No / ?
14. wake up with headaches in the morning?.....Yes / No / ?
15. Did your child stop grow at a normal rate at any time since birth?.....Yes / No / ?
16. Is your child overweight?.....Yes / No / ?

My child often...

17. does not seem to listen when spoken to directly.....Yes / No / ?
18. has difficulty organizing tasks and activities.....Yes / No / ?
19. is easily distracted by extraneous stimuli.....Yes / No / ?
20. fidgets with hands or feet or squirms in seat.....Yes / No / ?
21. is “on the go” or often acts as if “driven by a motor”.....Yes / No / ?
22. interrupts or intrudes on others (e.g. butts into conversations or games).....Yes / No / ?

**** If the answer to more than 1/3 of responses (excluding “?”) is “Yes”, referral to a physician to evaluate for sleep-disordered breathing is recommended.**

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OFFICE USE Reviewed:
