Sleep, Breathing & Habit Questionnaire

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

Please indicate if your child experiences any of the symptoms below by using this scale to measure the severity of these symptoms.

0 - No Occurrence 1 - Occures Rarely 2 - Occurs 2 to 4 times per week 3 - Occurs 5 to 7 times per week

1. _____ Snoring
2. _____ Interrupted snoring where breathing stops
3. _____ Labored, difficult or loud breathing at night
4. _____ Gasping for air while sleeping
5. _____ Mouth breathes while sleeping
6. _____ Mouth breathes during the day
7. _____ Restless sleep
8. _____ Grinds teeth while sleeping
9. _____ Talks in sleep
10. _____ Excessive sweating while sleeping
11. _____ Wakes up at night
12. _____ Wets the bed (currently)
13. _____ History of bedwetting
14. _____ Feels sleepy and/or irritable during the day
15. _____ Headaches
16. _____ Frequent throat infections
17. _____ Allergic symptoms
18. _____ Ear infections
19. _____ Short attention span
20. _____ Trouble Focusing
21. _____ Difficulty listening/often interupts
22. _____ Hyperactive
23. _____ ADD/ADHD
24. _____ Sensory Issues
25. _____ Struggles in math at school
26. _____ Struggles in reading at school
27. _____ Speech problems *
28. _____ Avoidance behavior towards food or or certain types of food

Speech Questionnaire - to be filled out only if #27 was indicated above

Please check all that apply to your child

_____ Is it difficult to understand your child's speech?

_____ Difficult to understand over the phone?

_____ Nasal speech?

_____ Hoarseness?

_____ Others have difficulty understanding speech?

_____ Gets frustrated when people can't understand speech?

_____ Speech sounds abnormal?

_____ Sometimes omits consonants?

_____ Uses M, N, NG instead of P, V, S, Z sounds?

_____ Swallowing problems with liquids and solids getting into nose?

Pediatric Sleep Questionnaire: Sleep-Disordered Breathing Subscale*

Child's Name: _____ Study ID #: _____
Person completing form: _____ Date: ____/____/____
Please answer these questions regarding the behavior of your child during sleep and wakefulness. The questions apply to how your child acts in general during the past month, not necessarily during the past few days since these may not have been typical if your child has not been well. You should circle the correct response or *print* your answers neatly in the space provided. A "Y" means "yes," "N" means "no," and "DK" means "don't know."

1. WHILE SLEEPING, DOES YOUR CHILD:
Snore more than half the time?……. ……Y N DK A2
Always snore? ……...Y N DK A3
Snore loudly? ……Y N DK A4
Have "heavy" or loud breathing? …….…… Y N DK A5
Have trouble breathing, or struggle to breathe? …….…… ..Y N DK A6

2. HAVE YOU EVER SEEN YOUR CHILD STOP BREATHING DURING THE NIGHT? ……Y N DK A7

3. DOES YOUR CHILD:
Tend to breathe through the mouth during the day?……Y N DK A24
Have a dry mouth on waking up in the morning? ……...Y N DK A25
Occasionally wet the bed? ……...Y N DK A32

4. DOES YOUR CHILD:
Wake up feeling unrefreshed in the morning? …….Y N DK B1
Have a problem with sleepiness during the day? …….…….…...Y N DK B2

5. HAS A TEACHER OR OTHER SUPERVISOR COMMENTED THAT YOUR CHILD APPEARS SLEEPY DURING THE DAY? ……Y N DK B4

6. IS IT HARD TO WAKE YOUR CHILD UP IN THE MORNING? ……Y N DK B6

7. DOES YOUR CHILD WAKE UP WITH HEADACHES IN THE MORNING?…..Y N DK B7

8. DID YOUR CHILD STOP GROWING AT A NORMAL RATE AT ANY TIME SINCE BIRTH? …….Y N DK B9

9. IS YOUR CHILD OVERWEIGHT? …….Y N DK B22

10. THIS CHILD **OFTEN**:
Does not seem to listen when spoken to directly. ……....Y N DK C3
Has difficulty organizing tasks and activities. …….……....Y N DK C5
Is easily distracted by extraneous stimuli. …….……...Y N DK C8
Fidgets with hands or feet or squirms in seat. …….....Y N DK C10
Is "on the go" or often acts as if "driven by a motor". ……Y N DK C14
Interrupts or intrudes on others (eg., butts into conversations or games). ……Y N DK C18

Child's height _____
Child's weight _____

Thank You!

Grading the Pediatric Sleep Questionnaire and Sleep Disordered Breathing Sub-Scale

Pediatric Sleep Questionnaire:

Count and total up the number of "yes" answers and divide by 65. Record this number that should be between 0 and 1 on your case report form.

Results greater than 0.33 are positive and indicate a high probability of sleep disordered breathing.

Sleep Disordered Breathing Sub-Scale:

Count and total up the number of "yes" answers and divide by 22. Record this number that should be between 0 and 1 on your case report form.