

Pediatric Sleep Questionnaire

Please fill this out as accurately and honestly as possible.

This screening tool gives us and you a validated way to measure your child's risk for OSA.

Patient Name:		Date:		
D. O. B	Age	Yes	No	Don't
				Know
have trouble breathing or struggle	While sleeping does your child			
have trouble breathing or struggle to breathe? stop breathing during the night?				_
have "heavy" or "loud" breathing?				_
snore regularly?				
snore loudly?				
snore more than half the time?				
appear to be a restless sleeper?				-
child kicks during sleep?				+
have nightmares?				-
scream in their sleep?				
grind their teeth during sleep?				
sleepwalk?				
occasionally wet the bed? If so, how often?				
How many hours does your child sleep (average), including naps? Please circle below				•
Less than 6 6-7 7-8 8-9	9 9-10 10-12 13-15 15-17			
	Upon awakening, does your child			
have a dry mouth in the morning?				
tend to breathe through the mouth during the day?				
wake up feeling un-refreshed in the morning?				
have a problem with sleepiness during the day?				
have trouble getting going in the morning?				
wake up with headaches in the morning?				
	We have noticed that our child			<u> </u>
does not seem to listen when spoken to directly				
has difficulty organizing tasks				
is easily distracted by extraneous stimuli				
fidgets with hands or feet or squirms in seat				
interrupts or intrudes on others (butts into conversations or games)				_
has a teacher/supervisor commented that your child appears sleepy during the day				_
has been diagnosed with ADD or A				
	Additionally			T
did your child stop growing at a normal rate at any time since birth?				
is your child overweight?				
does your child have allergies?				1

The American Academy of Sleep Medicine Recommended Sleep Times:

Toddlers (1-2 years) 11-14 hours
Preschool (3-5 years) 10-13 hours
School Aged (6-12 years) 9-12 hours
Teenagers (13-18 years) 8-10 hours