Pediatric Sleep Questionnaire

Name of Child: _____ Date of Birth: _____

Person completing this form: _____ Relationship: _____

Today's Date: _____

INSTRUCTIONS: Please answer the questions about your child OVER THE PAST MONTH. For this questionnaire, "usually" means at least than half the time or more

	Yes	No	Don't Know
1. While Sleeping, does your child			
Snore more than half the time?	Y	N	DK
Always snore?	Y	N	DK
Snore loudly?	Y	N	DK
Have "heavy" or loud breathing?	Y	N	DK
Have trouble breathing, or struggle to breath?	Y	N	DK
2. Have you ever seen your child stop breathing during the night?	Y	N	DK
3. Does your child:			
Tend to breath through the mouth during the day?	Y	N	DK
Have a dry mouth on walking up in the morning?	Y	N	DK
Occasionally wet the bed?	Y	N	DK
4. Does your Child			
Wake up feeling unrefreshed in the morning?	Y	N	DK
Have a problem with sleepiness during the day?	Y	N	DK
5. Has a teacher or supervisor commented that your child appears sleepy during the day?	Y	N	DK
6. Is it hard to wake your child up in the morning?	Y	N	DK
7. Does your child wake up with headaches in the morning?	Y	N	DK
8. Did your child stop growing at a normal rate at any time since birth?	Y	N	DK
9. Is your child overweight?	Y	N	DK
10. This child often			
Does not seem to listen when spoken to directly	Y	N	DK
Has difficulty organizing tasks and activities	Y	N	DK
Is easily distracted by extraneous stimuli	Y	N	DK
Fidgets with hands, feet, or squirms in seat	Y	N	DK
Is "on the go" or often act as if "driven by a motor"	Y	N	DK
Interrupts or intrudes on others (eg butts into conversations or games)	Y	N	DK

Dr. Michael Major

THE SNORE CENTRE
pediatrics@thesnorecentre.com
780.761.6671