Center for early Orthodontic treatment

Pediatric Sleep Questionnaire: Sleep-Disordered Breathing Subscale

Child's Name: _____ **Date:** ____/____/____

Person completing form / Relationship to child: _____

How often would you say your child has difficulty breathing when he/she is sleeping?

NEVER OCCASIONALLY FREQUENTLY CONSTANTLY

How often would you say your child snores?

NEVER OCCASIONALLY FREQUENTLY CONSTANTLY

1. While sleeping, does your child:

Snore more than half of the time?	Y	N	DK
Always snore?	Y	N	DK
Snore loudly?	Y	N	DK
Have a "heavy" or loud breathing?	Y	N	DK
Have trouble breathing, or struggle to breathe?	Y	N	DK

2. Have you ever seen your child stop breathing during the night? Y N DK

3. Does your child?

Tend to breathe through the mouth during the day?	Y	N	DK
Have a dry mouth on waking 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 other 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 or feet or squirms in seat	Y	N	DK
Is "on the go" or often acts as if "driven by a motor"	Y	N	DK
Interrupts or intrudes on others (e.g. butts into conversation or games)	Y	N	DK