PEDIATRIC QUESTIONNAIRE

1) Does your child have trouble going to bed or falling asleep? YES ☐ NO ☐
2) Awaken during the night and have trouble returning to sleep? YES ☐ NO ☐
3) Does he/she tend to breathe through their mouth during the day or during sleep? YES ☐ NO ☐
4) Have dry mouth or bad breath upon waking in the morning? YES ☐ NO ☐
5) Have you notice any of the following while your child is sleeping?
   * Snoring, heavy or loud breathing? YES ☐ NO ☐
   * Break or pause in breathing? YES ☐ NO ☐
   * Gasp, choke, or struggle to breathe? YES ☐ NO ☐
   * Restless or agitated sleep? Grinding teeth? YES ☐ NO ☐
   * Abnormal head posture (hyper-extension, etc.) YES ☐ NO ☐
   * Excessive sweating? YES ☐ NO ☐
   * Wetting the bed? YES ☐ NO ☐
6) Have you noticed any of the following during the day?
   * Difficulty waking? YES ☐ NO ☐
   * Wakes with headaches? YES ☐ NO ☐
   * Groggy, tired or “out of it”? YES ☐ NO ☐
   * Hyperactive? YES ☐ NO ☐
   * Teachers commented? YES ☐ NO ☐
7) Child often:
   * Does not seem to listen when spoken to directly? YES ☐ NO ☐
   * Has difficulty organizing tasks? YES ☐ NO ☐
   * Easily distracted by extraneous stimuli? YES ☐ NO ☐
   * Fidgets with hands or feet or squirms in seat? YES ☐ NO ☐
   * Interrupts or intrudes on others? YES ☐ NO ☐
8) Is your child frequently sick, have a history of sore throat, ear infections, sinus infections, or allergies? YES ☐ NO ☐
9) Stop growing at a normal rate at any time since birth? Overweight?
10) Habits such as: Pacifier ☐ Thumb sucking ☐ Lip biting ☐ other? _____

Patient Name: _____