Patient Form

healthystart

Doctor: _____

Child's Name _____ Age _____ Date: _____

Filled Out By: _____ Relationship to Patient: _____

Sleep Disordered Breathing Questionnaire for Children

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The initial column should be filled out at first appointment, and the follow up column should be completed after 3 months of treatment. Please identify the following symptoms your child exhibits with the scale indicating severity of symptoms.

0 – Not Present 1 – 2 Mild 3 Moderate 4 - 5 Pronounced

Does your child:

	INITAL	FOLLOW UP	
1.	____	____	Snore at all?
2.	____	____	Snore only infrequently (1 night/week)
3.	____	____	Snore fairly often (2-4 nights/week)
4.	____	____	Snore habitually (5-7 nights/week)
5.	____	____	Have labored, difficult, loud breathing at night
6.	____	____	Have interrupted snoring where breathing stops for 4 or more seconds
7.	____	____	Have stoppage of breathing more than 2 times in an hour
8.	____	____	Hyperactive
9.	____	____	Mouth breathes during day
10.	____	____	Mouth breathes while sleeping
11.	____	____	Frequent headaches in morning
12.	____	____	Allergic symptoms
13.	____	____	Excessive sweating while asleep

	INITAL	FOLLOW UP	
14.	____	____	Talks in sleep
15.	____	____	Poor ability in school
16.	____	____	Falls asleep watching TV
17.	____	____	Wakes up at night
18.	____	____	Attention deficit
19.	____	____	Restless sleep
20.	____	____	Grinds teeth
21.	____	____	Frequent throat infections
22.	____	____	Feels sleepy and/or irritable during the day
23.	____	____	Have a hard time listening and often interrupts
24.	____	____	Fidgets with hands or does not sit quietly
25.	____	____	Ever wets the bed
26.	____	____	Bluish color at night or during the day
27.	____	____	Speech Problems *

*If yes, provide parent speech questionnaire

Was your reason for coming to this doctor for sleep or dental issues: _____

Based on Sahin et al, 2009; and Urschitz et al, 2004; AM Thoracic Soc Stand, 1996; Attanasio et al, 2010

Speech Questionnaire

To be filled out only if #27 was indicated above

Please check all that apply to your child:

	INITAL	FOLLOW UP	
28.	____	____	Is it difficult to understand your child's speech
29.	____	____	Difficult to understand over the phone?
30.	____	____	Nasal speech?
31.	____	____	Speech sounds abnormal?
32.	____	____	Others have difficulty understanding speech?

	INITAL	FOLLOW UP	
33.	____	____	Gets frustrated when people can't understand speech?
34.	____	____	Sometimes omits consonants
35.	____	____	Uses M, N, NG instead of P, F, V, S, Z sounds
36.	____	____	Hoarseness
37.	____	____	Lisp
38.	____	____	Any speech therapy?

How Long? _____

Based on Barr et al, 2007