Patient Form

healthystart.

Parent Name: ______________________________

City: ____________________ State: _________ Age: _______ Male or Female: _______________

Current Dentist: __________________________ Current Pediatrician: __________________________

Sleep Disordered Breathing Questionnaire for Children

Earl O. Bergersen, DDS, MSD

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

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

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

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

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

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