Patient Form

healthystart

Doctor: ____________

Child's Name ____________ Age ______ Date: ____________

Filled Out By: ____________ Relationship to Patient: ____________

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	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
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?
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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