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
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:

1. ____ Is it difficult to understand your child's speech
2. ____ Difficult to understand over the phone?
3. ____ Nasal speech?
4. ____ Speech sounds abnormal?
5. ____ Others have difficulty understanding speech?
6. ____ Gets frustrated when people can't understand speech?
7. ____ Sometimes omits consonants
8. ____ Uses M, N, NG instead of P, F, V, S, Z sounds
9. ____ Hoarseness
10. ____ Lisp
11. ____ Any speech therapy?
    How Long? _____

Based on Barr et al, 2007