

Sleep, Breathing & Habit Questionnaire

Children & Adolescents

Full Name:

Age:

Date:

Please indicate if your child experiences or has experienced any of these symptoms below by using this scale to measure the severity of these symptoms.

0 - No Occurrence 1 - Occurs Rarely 2 - Occurs 2 to 4 times per week 3 - Occurs 5 to 7 times per week

- | | |
|--|--|
| 1. _____ Snoring | 15. _____ Headaches |
| 2. _____ Interrupted snoring where breathing stops | 16. _____ Frequent throat infections |
| 3. _____ Labored, difficult or loud breathing at night | 17. _____ Seasonal allergies |
| 4. _____ Gasping for air while sleeping | 18. _____ Ear infections or history of ear infections |
| 5. _____ Mouth breathes while sleeping | 19. _____ Short attention span |
| 6. _____ Mouth breathes during day | 20. _____ Trouble focusing |
| 7. _____ Restless sleep | 21. _____ Difficulty listening/ often interrupts |
| 8. _____ Grinds teeth while sleeping | 22. _____ Hyperactive |
| 9. _____ Talks in sleep | 23. _____ ADD/ADHD |
| 10. _____ Excessive sweating while sleeping | 24. _____ Sensory Issues |
| 11. _____ Wakes up at night | 25. _____ Struggles in math at school |
| 12. _____ Wets the bed (currently) | 26. _____ Struggles in reading at school |
| 13. _____ History of bed wetting | 27. _____ Speech issues* |
| 14. _____ Feels sleepy and/or irritable during the day | 28. _____ Avoidance behavior towards food or certain types of food |

*Speech Questionnaire - to be filled out only if #27 was indicated above

Please check all that apply

- | | |
|--|--|
| _____ Is it difficult to understand your child's speech? | _____ Gets frustrated when people can't understand speech? |
| _____ Difficult to understand over the phone? | _____ Speech sounds abnormal? |
| _____ Nasal speech? | _____ Sometimes omits consonants? |
| _____ Hoarseness? | _____ Uses M, N, NG instead of P, V, S, Z sounds? |
| _____ Other have difficulty understanding speech? | _____ Liquids and/or solids get into nasal area when eating or drinking? |

Adult Sleep & Breathing Questionnaire

Date: _____

Patient 's Name: _____

Patient's Date of Birth: _____ Age: _____

Male _____ Female _____

Have you ever had a sleep test administered? _____ yes _____ no

If yes - when did you have your last sleep test? _____

Have you been diagnosed with Sleep Apnea? _____ yes _____ no

Do you currently use a CPAP or Sleep Appliance for Sleep Apnea? _____ yes _____ no

Are you happy with your CPAP or Sleep Appliance? _____ yes _____ no

If you are not happy - why? _____

How often do you get out of bed to use the restroom during the night? _____

	Yes	No
Do you usually wake feeling tired and unrested?	<input type="checkbox"/>	<input type="checkbox"/>
Do you habitually snore?	<input type="checkbox"/>	<input type="checkbox"/>
Have you been diagnosed with Hypertension/High Blood Pressure?	<input type="checkbox"/>	<input type="checkbox"/>
Do you often suffer from waking headaches?	<input type="checkbox"/>	<input type="checkbox"/>
Do you regularly experience daytime drowsiness or fatigue?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have blocked nasal passages?	<input type="checkbox"/>	<input type="checkbox"/>
Has anyone observed you stop breathing during your sleep?	<input type="checkbox"/>	<input type="checkbox"/>
Do you ever wake up choking or gasping?	<input type="checkbox"/>	<input type="checkbox"/>
Do you grind your teeth while sleeping?	<input type="checkbox"/>	<input type="checkbox"/>
Is your neck circumference greater than 40 cm/ 15.75" ?	<input type="checkbox"/>	<input type="checkbox"/>
Is your Body Mass Index (BMI) more than 35?	<input type="checkbox"/>	<input type="checkbox"/>

BMI Formula

BMI =

(your weight in pounds X 703)

(your height in inches X your height in inches)