Dr. Douglas E. Smith

Initial Appointment

Child's Name ______________________________ Age _______ Date _______________________

Filled Out By ______________________________ Relationship to Patient ______________________

Sleep Disordered Breathing Questionnaire for Children
Dr. Douglas E. Smith

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

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, please complete speech questionnaire

Speech Questionnaire
To be filled out only if #27 was indicated above

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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. Other 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? _______
    If so how long? _______

Diagnostic Data and Information

Dr. Douglas E. Smith

Patient Name ____ Date _______________

Patient Birthday_________________ Age _________ Male / Female Ethnicity ______________________

Reason for Office Visit for Dental or Sleep Issues ____

Sleep Disorders

Condition Present	Yes	No
Snores 3-7 Nights/Week	☐	☐
Interrupted Snoring	☐	☐
Mouth Breathing, Days	☐	☐
Mouth Breathing, Nights	☐	☐
Nasal Breathing Difficult	☐	☐
Swollen Tonsils	☐	☐
Speech Problems	☐	☐
Venous Pooling Under the Eyes (Dark circles)	☐	☐

Habits

Condition Present	Yes	No
Anterior Tongue Thrust	☐	☐
Sucks Fingers, Nights	☐	☐
Sucks Fingers, Day & Night	☐	☐
Swallowing Problems	☐	☐
Tongue-tied	☐	☐

Height

Height ________” Father ________” Mother________”

Older Sibling: Sister _________” Age________

Brother ________” Age________

Misc. Questions

		Yes	No
Breast Fed – To What Age?	_________	☐	☐
Bottle Fed – How Long?	_________	☐	☐
Pacifier Use – How Long?	_________	☐	☐
Speech Lessons – How Long?	_________	☐	☐
Rest Jaw on Fist – Frequent?	_________	☐	☐
Signs of Maturity – At What Age?	_________	☐	☐
(1st Menses, Female) (Lower Voice, Male)		☐	☐