Pediatric Sleep Questionnaire

Patient Name: _____

Please answer the following questions as they pertain to your child in the past month

Y=Yes N=No DK=Don't Know

1. While sleeping, does your child:			
• Snore more than half the time?	**Y**	**N**	**DK**
• Always snore?	**Y**	**N**	**DK**
• Snore loudly?	**Y**	**N**	**DK**
• Have "heavy" or loud breathing?	**Y**	**N**	**DK**
• Have trouble breathing, or struggle to breathe?	**Y**	**N**	**DK**
2. Have you ever seen your child stop breathing during the night?	**Y**	**N**	**DK**
3. Does your child:			
• Tend to breathe through the mouth during the day?	**Y**	**N**	**DK**
• Have a dry mouth on waking up in the morning?	**Y**	**N**	**DK**
• Occasionally wet the bed?	**Y**	**N**	**DK**
4. Does your child:			
• Wake up feeling unrefreshed in the morning?	**Y**	**N**	**DK**
• Have a problem with sleepiness during the day?	**Y**	**N**	**DK**
5. Has a teacher or other supervisor commented that your child appears sleepy during the day?	**Y**	**N**	**DK**
6. Is it hard to wake your child up in the morning?	**Y**	**N**	**DK**
7. Does your child wake up with headaches in the morning?	**Y**	**N**	**DK**
8. Did your child stop growing at a normal rate at any time since birth?	**Y**	**N**	**DK**
9. Is your child overweight?	**Y**	**N**	**DK**
10. This child often:			
• Does not seem to listen when spoken to directly	**Y**	**N**	**DK**
• Has difficulty organizing tasks and activities	**Y**	**N**	**DK**
• Is easily distracted by extraneous stimuli	**Y**	**N**	**DK**
• Fidgets with hands or feet or squirms in seat	**Y**	**N**	**DK**
• Is "on the go" or often acts if "driven by a motor"	**Y**	**N**	**DK**
• Interrupts or intrudes on others (e.g., butts into conversations or games)	**Y**	**N**	**DK**

Signature of Responsible Party: _____