Progressive Dental Solutions

PEDIATRIC/ADOLESCENT SLEEP QUESTIONNAIRE

Patient Name: _____ Date of Birth: _____

Please place a checkmark next to all statements that apply.

While Sleeping, Does Your Child:

_____ Snore more than half the time
_____ Always snore
_____ Have heavy or loud breathing
_____ Snore loudly
_____ Have trouble breathing or struggles to breathe
_____ Ever stop breathing at night

Does Your Child…?:

_____ Tend to breathe through the mouth during the day
_____ Have a dry mouth upon waking up in the morning
_____ Occasionally wet the bed
_____ Grind his/her teeth while sleeping
_____ Have any bite problems or crowded teeth
_____ Wake up unrefreshed in the morning
_____ Have a problem with daytme sleepiness
_____ Have a teacher or anyone who has commented about sleepiness during the day
_____ Have difficulty waking up in the morning
_____ Wake up with headaches
_____ Have any history of growth problems
_____ Have an overweight issue: Weight is _____
Height is _____
_____ Complain of restless or achy legs
_____ Have arms and/or legs that twitch during sleep
_____ Have nightmares (more than one per week)

Signature of person completing questionnaire: _____

Name of person completing questionnaire if not patient: _____