

Pediatric Sleep Questionnaire

(Screening)

Name of the child: _____

Date of birth: _____

Person completing this form: _____

Date that you are completing the questionnaire: _____

Instructions: Please answer the questions about how your child **IN THE PAST MONTH**. Circle the correct response or *print* your answers in the space provided. “Y” means “yes,” “N” means “no,” and “DK” means “don’t know.” For this questionnaire, the word “usually” means “more than half the time” or “on more than half the nights.”

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

	YES	NO	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 breath?	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 as if “driven by a motor”	Y	N	DK
Interrupts or intrudes on others (eg butts into conversations or games)	Y	N	DK