Ghina Morad, DMD
Beautiful Faces, Radiant Smiles

Pediatric Sleep Questionnaire

Last Name: ______ First Name: ______ Birthdate: ______

1. Does your child snore more than half the time? ☐ Yes ☐ No
2. Does your child snore all the time? ☐ Yes ☐ No
3. Does your child snore loudly? ☐ Yes ☐ No
4. Can you hear your child breathing heavily or loudly during their sleep? ☐ Yes ☐ No
5. Does your child pause or stop breathing during their sleep? ☐ Yes ☐ No
6. Does your child struggle to breath during their sleep? ☐ Yes ☐ No
7. Can you hear your child grinding their teeth at night? ☐ Yes ☐ No
8. Does your child fall asleep during the day inappropriately? ☐ Yes ☐ No
9. Is your child hyperactive? ☐ Yes ☐ No
10. Does your child have bedwetting? ☐ Yes ☐ No
11. Does your child breath through their mouth or have their lips separated during the day or night? ☐ Yes ☐ No
12. Does your child wakeup with a dry mouth? ☐ Yes ☐ No
13. Does your child wake up unrefreshed in the morning? ☐ Yes ☐ No
14. Do you have a hard time waking them up? ☐ Yes ☐ No
15. Does your child wake up with headache? ☐ Yes ☐ No
16. Has your child slow down in the rate of normal growth since birth? ☐ Yes ☐ No
17. Does your child not seem to listen when you speak to them directly? ☐ Yes ☐ No
18. Does your child struggle with organizing tasks? ☐ Yes ☐ No
19. Does your child get easily distracted with outside stimuli? ☐ Yes ☐ No
20. Does your child fidget or squirm in their seat ? ☐ Yes ☐ No
21. Is your child too active and seems to be always on the go? ☐ Yes ☐ No
22. Does your child interrupt others during a conversation or a game? ☐ Yes ☐ No

Signature ______

Today's Date: ______

If signed by a personal representative of the patient, describe the representative's relationship to and authority to act for patient.

Representative's Name: ______

Relationship: ______