Pediatric Sleep Questionnaire

Patient's Name: _____

Did your child have Adenotonsillectomy Surgery? Yes / No No

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

	While Sleeping, Does Your Child:	**Yes**	**No**	**Don't Know**
1	Snore more than half the time?	○	○	○
2	Always snore?	○	○	○
3	Sore Loudly?	○	○	○
4	Have "heavy" or loud breathing?	○	○	○
5	Have trouble breathing, or struggle to breathe?	○	○	○
6	Have you ever seen your child stop breathing during the night?	○	○	○
	Does Your Child:	**Yes**	**No**	**Don't Know**
7	Tend to breathe through the mouth during the day?	○	○	○
8	Have a dry mouth upon waking up in the morning?	○	○	○
9	Occasionally wet the bed?	○	○	○
10	Wake up feeling unrefreshed in the morning?	○	○	○
11	Have a problem with sleepiness during the day?	○	○	○
12	Has a teacher or other supervisor commented that your child appears sleeping during the day?	○	○	○
13	Is it hard to wake your child up in the morning?	○	○	○
14	Does your child wake up with headaches in the morning?	○	○	○
15	Did your child stop growing at a normal rate at any time since birth?	○	○	○
16	Is your child overweight?	○	○	○
	This Child Often:	**Yes**	**No**	**Don't Know**
17	Does not seem to listen when spoken to directly	○	○	○
18	Has difficulty organizing tasks and activities	○	○	○
19	Is easily distracted by extraneous stimuli	○	○	○
20	Fidgets with hands or feet or squirms in seat	○	○	○
21	Is "on the go" or often acts as if "driven by a motor"	○	○	○
22	Interrupts or intrudes on others (eg., butts into conversations or games)	○	○	○