Glenmore Park Dental

Pediatric Sleep Medicine Screening

Patient Name:_____ Date: _____

Please complete this form as accurately and honestly as possible. In our practice we are very interested in our patients' overall health. Dental treatment can be an important part of managing the health problems caused by sleep and breathing disorders.

Please circle 'Y' for yes, 'N' for no and 'DK' for don't know.

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
HAVE YOU EVER SEEN YOUR CHILD STOP BREATHING DURING THE NIGHT?	Y	N	DK
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
DOES YOUR CHILD:			
Wake up feeling unrefreshed in the morning?	Y	N	DK
Have a problem with sleepiness during the day?	Y	N	DK
HAS A TEACHER OR OTHER SUPERVISOR COMMENTED THAT YOUR CHILD SEEMS SLEEPY DURING THE DAY?	Y	N	DK
IS IT HARD TO WAKE YOUR CHILD UP IN THE MORNING?	Y	N	DK
DOES YOUR CHILD WAKE UP WITH HEADACHES?	Y	N	DK
DID YOUR CHILD STOP GROWING AT A NORMAL RATE AT ANY TIME SINCE BIRTH?	Y	N	DK
IS YOUR CHILD OVERWEIGHT?	Y	N	DK
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 (butts into conversations or games)	Y	N	DK