Appendix 6

PEDIATRIC SLEEP QUESTIONNAIRE
PATIENTS UNDER 18 YEARS OF AGE

Last Name ……..…… First Name ……..……..…… Age ……. Date ……..

Please answer on behalf of your child for the past month.
If you don't know, circle "?"

While sleeping, does your child . . .

1. snore more than half the time? …… Yes / No / ?
2. always snore? …… Yes / No / ?
3. snore loudly? …… Yes / No / ?
4. have trouble breathing, or struggle to breathe? …… Yes / No / ?
5. have "heavy" or loud breathing? …… Yes / No / ?
6. have you ever seen your child stop breathing during the night? …… Yes / No / ?

Does your child . . .

7. tend to breathe through the mouth during the day? …… Yes / No / ?
8. have a dry mouth on waking up in the morning? …… Yes / No / ?
9. occasionally wet the bed? …… Yes / No / ?
10. wake up feeling unrefreshed in the morning? …… Yes / No / ?
11. have a problem with sleepiness during the day? ……Yes / No / ?
12. has a teacher commented that your child appears sleepy during the day? ……Yes / No / ?
13. is it hard to wake your child up in the morning? …… Yes / No / ?
14. does your child wake up with headaches in the morning? …… Yes / No / ?
15. did your child stop growing at a normal rate at any time since birth? ……Yes / No / ?
16. is your child overweight? …… Yes / No / ?

My child often . . .

17. does not seem to listen when spoken to directly. ……Yes / No / ?
18. has difficulty organizing task and activities. …… Yes / No / ?
19. is easily distracted by extraneous stimuli. …… Yes / No / ?
20. fidgets with hands or feet or squirms in seat. …… Yes / No / ?
21. is 'on the go' or often acts as if 'driven by a motor'. …… Yes / No / ?
22. interrupts or intrudes on others (e.g. butts into conversations or games) …… Yes / No / ?