Pediatric Sleep Questionnaire

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Name: ______________________________ Age: ___________ Date: ____________________

While sleeping, does your child:	Yes	No
Snore more than half the time?		
Always snore?		
Have “heavy” or loud breathing?		
Have trouble breathing, or struggle to breathe?		
Have you ever…		
Seen your child stop breathing during the night?		
Does your child:		
Tend to breathe though the mouth during the day?		
Have a dry mouth on waking up in the morning?		
Occasionally wet the bed?		
Wake up feeling unrefreshed in the morning?		
Have a problem with sleepiness during the day?		
Wake up with headaches in the morning?		
This child often:		
Does not seem to listen when spoken to directly.		
Has difficulty organizing tasks.		
Is easily distracted by extraneous stimuli?		
Fidgets with hands or feet or squirms in seat?		
Is on the go or often acts as if ‘driven by a motor’?		
Interrupts or intrudes on others (i.e butts into conversations or games)?		
Is it hard to wake your child up in the morning?		
Has a teacher or other supervisor commented that your child appears sleepy during the day?		
Did your child stop growing at a normal rate at any time since birth?		
Is your child overweight?		

Total # of yes: __________

CHERVINE ET AL, PEDIATRIC SLEEP QUESTIONNAIRE: VALIDITY AND RELIABILITY OF SCALES FOR SLEEP DISORDERED BREATHING, SNORING, SLEEPINESS, AND BEHAVIORAL PROBLEMS, SLEEP MEDICINE 2000;1:21-32

More than 8 positive responses may indicate a problem with a sleep related breathing disorder.