ARDENTE DENTAL, PSC/JILL M. SNYDER, DDS

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Pediatric/Adolescent Sleep Questionnaire

Patient:_____ Date of Birth:_____

Please mark all that apply.

While Sleeping, Does Your Child:

- Snore more than half the time
- Always snore
- Have heavy or loud breathing
- Snore Loudly
- Have trouble breathing or struggles to breathe
- Ever stop breathing at night

Does your child……?

- Tend to breathe through the mouth during the day
- Have a dry mouth upon waking up in the morning
- Occasionally wet the bed
- Grind his/her teeth while sleeping
- Have any bite problems or crowded teeth
- Wake up un-refreshed in the morning
- Have a problem with daytime sleepiness
- Have a teacher or anyone who has commented about sleepiness during the day
- Have difficulty waking up in the morning
- Wake up with headaches
- Have any history of growth hormones
- Have an overweight issue: Weight_____ Height_____
- Complain of restless or achy legs
- Have arms and/or legs that twitch during sleep
- Have nightmares (more than one per week)

Signature of person completing questionnaire: _____

Name of person completing questionnaire if not patient:_____