Patient Form

healthystart®

POSTFALLS Family Dental

Doctor/Dentist: _____

Patient's Name: _____ DOB: _____ Age: _____

Filled Out By: _____ Relationship to Patient: _____

Sleep Disordered Breathing Questionnaire for Children

Earl O. Bergersen, DDS, MSD

Please indicate to what degree your child exhibits any of the following symptoms using the scale of severity below. The initial score column should be evaluated and dated at first appointment and the follow-up score column should be evaluated and dated after 3 months of treatment by the same person who filled out the initial assessment.

Date of Initial Assessment: _____ Date of Follow-up Assessment: _____

Filled Out By: _____

Not Present: 0 Very Mild: 1 Mild: 2 Moderate: 3 Pronounced: 4 Severe: 5

	INITIAL SCORE	FOLLOW-UP SCORE	
1.	_____	_____	Snoring of any kind
2.	_____	_____	Snores only infrequently (1 night/week)
3.	_____	_____	Snores fairly often (2-4 nights/week)
4.	_____	_____	Snores habitually (5-7 nights/week)
5.	_____	_____	Has labored, difficult, loud breathing at night
6.	_____	_____	Has interrupted snoring where breathing stops for 4 or more seconds
7.	_____	_____	Has stoppage of breathing more than 2 times in an hour
8.	_____	_____	Hyperactive
9.	_____	_____	Mouth breathes during day
10.	_____	_____	Mouth breathes while sleeping
11.	_____	_____	Frequent headaches in morning
12.	_____	_____	Allergy symptoms*: ☐ Asthma ☐ Eczema ☐ Nasal congestion ☐ Other: _____
13.	_____	_____	Excessive sweating while asleep
14.	_____	_____	Talks in sleep
15.	_____	_____	Poor ability in school*: ☐ Math ☐ Science ☐ Spelling ☐ Reading ☐ Writing
16.	_____	_____	Falls asleep watching TV
17.	_____	_____	Wakes up at night
18.	_____	_____	Attention deficit
19.	_____	_____	Restless sleep
20.	_____	_____	Grinds teeth
21.	_____	_____	Frequent throat infections
22.	_____	_____	Feels sleepy and/or irritable during the day
23.	_____	_____	Difficult time listening and often interrupts
24.	_____	_____	Fidgets with hands or does not sit quietly*: ☐ Muscular tics ☐ Restless (wiggles) legs
25.	_____	_____	Ever wets the bed
26.	_____	_____	Bluish color at night or during the day
27.	_____	_____	Nightmares and/or night terrors
28.	_____	_____	Exhibits any of the following*: ☐ Rarely smiles ☐ Feels sad ☐ Feels depressed
29.	_____	_____	Speech problems**

**If scored greater than 0, please continue to Speech Questionnaire below

*Please indicate with a ☒ if condition is present

Was the reason for coming to this doctor for SLEEP or DENTAL issues?_____

Based on Sahin et al, 2009; and Urschitz et al, 2004; AM Thoracic Soc Stand, 1996; Attanasio et al, 2010

Speech Questionnaire

To be filled out only if #29 was indicated

	INITIAL SCORE	FOLLOW-UP SCORE	
30.	_____	_____	Nasal speech
31.	_____	_____	Speech sounds abnormal
32.	_____	_____	Others have difficulty understanding speech
33.	_____	_____	Sometimes omits consonants
34.	_____	_____	Uses M, N, NG instead of P, F, V, S, Z sounds
35.	_____	_____	Hoarseness
36.	_____	_____	Lisp
37.	_____	_____	Any speech therapy? If so, for how long? _____

Based on Barr et al, 2007

Revised 4/8/2019