Patient Form

healthystart™

Doctor: ____________________

Child's Name ______________________________ Age ________ Date: ____________________

Filled Out By: ______________________________ Relationship to Patient: ____________________

Sleep Disordered Breathing Questionnaire for Children by Earl O. Bergersen, DDS, MSD

Treatment Available at Amistad Dentistry - Dr. Thomas Taylor, DMD

The initial column should be filled out at first appointment, and the follow up column should be completed after 3 months of treatment. Please identify the following symptoms your child exhibits with the scale indicating severity of symptoms.

0 – Not Present   1 – 2 Mild   3 Moderate   4 - 5 Pronounced

Does your child:

#	INITAL	FOLLOW UP	
1.			Snore at all?
2.			Snore only infrequently (1 night/week)
3.			Snore fairly often (2-4 nights/week)
4.			Snore habitually (5-7 nights/week)
5.			Have labored, difficult, loud breathing at night
6.			Have interrupted snoring where breathing stops for 4 or more seconds
7.			Have 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.			Allergic symptoms
13.			Excessive sweating while asleep
14.			Talks in sleep
15.			Poor ability in school
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.			Have a hard time listening and often interrupts
24.			Fidgets with hands or does not sit quietly
25.			Ever wets the bed
26.			Bluish color at night or during the day
27.			Speech Problems *

*If yes, provide parent speech questionnaire

Was your 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 #27 was indicated above

Please check all that apply to your child:

#	INITAL	FOLLOW UP	
28.			Is it difficult to understand your child's speech
29.			Difficult to understand over the phone?
30.			Nasal speech?
31.			Speech sounds abnormal?
32.			Others have difficulty understanding speech?
33.			Gets frustrated when people can't understand speech?
34.			Sometimes omits consonants
35.			Uses M, N, NG instead of P, F, V, S, Z sounds
36.			Hoarseness
37.			Lisp
38.			Any speech therapy?

How Long? ____________________

Based on Barr et al, 2007

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