Kids Sleep Disordered Breathing Questionnaire

Doctor: ____________________

Child Name: ____________________ Age: __________ Date: ____________

Filled Out By: ____________________ Relationship to Patient: ____________________

Sleep Disordered Breathing and Oral Habit History

Was your child breast-fed?	Yes or	No	To what age? __________
Was your child bottle-fed?	Yes or	No	How long? __________
Did your child use a pacifier?	Yes or	No	How long? __________
Does your child rest on his/her wrist?	Yes or	No	Frequency? __________
Has your child reached maturity?	Yes or	No	What age? __________

(female: 1st menstrual cycle | Male: voice change)

Has your child's tonsil or adenoids been removed?	Yes or	No	When? __________
Does your child breathe normally through the nose?	Yes or	No	
Does your child have difficult or struggled breathing during sleep?	Yes or	No	
Does your child snore?	Yes or	No	
Did your child ever suck or bite his/her thumb, fingers, stuffed animals, blanket, nails or lip?	Yes or	No	
Does your child still suck his/her thumb, finger, stuffed animals, blanket, nails or lip?	Yes or	No	

____________________ Parent/Guardian Name

____________________ Date