

*Howard G. Hindin, D.D.S., P.C.*

*Jeffrey S. Hindin, D.D.S.*

*Jill I. Meyer, D.D.S.*

*Two Executive Blvd., Suite 206*

*Suffern, NY 10901*

*(845) 357-1595*

*Fax (845) 357-2428*

## Pediatric Sleep Disorder Questionnaire

Date: \_\_\_\_\_

Child's Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Sex: \_\_\_\_\_

Height: \_\_\_\_\_

Weight: \_\_\_\_\_

### While sleeping, does your child...

- ever snore? YES  NO
- snore more than half the time? YES  NO
- always snore? YES  NO
- snore loudly? YES  NO
- have "heavy" or loud breathing? YES  NO
- have trouble breathing, or struggle to breathe? YES  NO

### Have you ever...

- seen your child stop breathing during the night? YES  NO
- been concerned about your child's breathing during sleep? YES  NO
- had to shake your sleeping child to get him or her to breathe, or wake up and breathe? YES  NO
- seen your child wake up with a snorting sound? YES  NO

### Does your child have restless sleep? YES NO

- At night, does your child usually become sweaty, or do the pajamas usually become wet with perspiration? YES  NO
- At night, does your child usually get out of bed to urinate? YES  NO
- Does your child usually sleep with the mouth open? YES  NO
- Is your child's nose usually congested or "stuffed" at night? YES  NO
- Do any allergies affect your child's ability to breathe through the nose? YES  NO

### Does your child...

- tend to breathe through the mouth during the day? YES  NO
- have a dry mouth on waking up in the morning? YES  NO
- complain of an upset stomach at night? YES  NO
- get a burning feeling in the throat at night? YES  NO
- grind his or her teeth at night? YES  NO

- occasionally wet the bed? YES  NO
- wake up feeling unrefreshed in the morning? YES  NO
- have a problem with sleepiness during the day? YES  NO
- complain that he or she feels sleepy during the day? YES  NO
- Has a teacher/other supervisor commented that your child appears sleepy during the day? YES  NO
- Does your child usually take a nap during the day? YES  NO
- Is it hard to wake your child up in the morning? YES  NO
- Does your child wake up with headaches in the morning? YES  NO
- Did your child stop growing at a normal rate at any time since birth? YES  NO
- Is your child overweight? YES  NO

**This child often...**

- fails to give close attention to details or makes careless mistakes in schoolwork or other activities. YES  NO
- has difficulty sustaining attention in tasks or play activities. YES  NO
- does not seem to listen when spoken to directly. YES  NO
- does not follow through on instructions and fails to finish schoolwork, chores or duties. YES  NO
- has difficulty organizing task and activities. YES  NO
- avoids, dislikes, or is reluctant to engage in tasks or activities that require sustained mental effort (such as homework or schoolwork). YES  NO
- loses things necessary for tasks or activities (e.g., toys, school assignments, pencils, books or tools). YES  NO
- is easily distracted by extraneous stimuli. YES  NO
- is forgetful in daily activities. YES  NO
- idgets with hands or feet or squirms in seat. YES  NO
- leaves seat in classroom or in other situations in which remaining seated is expected. YES  NO
- runs about or climbs excessively in situations in which it is inappropriate. YES  NO
- has difficulty playing or engaging in leisure activities quietly. YES  NO
- is "on the go" or often acts as if "driven by a motor." YES  NO
- talks excessively. YES  NO
- blurts out answers before questions have been completed. YES  NO
- has difficulty awaiting his/her turn. YES  NO
- interrupts or intrudes on others (e.g., butts into conversations or games) YES  NO

Date: \_\_\_\_\_

Reviewed By: \_\_\_\_\_

Date: \_\_\_\_\_

Reviewed By: \_\_\_\_\_

Date: \_\_\_\_\_

Reviewed By: \_\_\_\_\_

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**EPWORTH SLEEPINESS SCALE**

NAME: \_\_\_\_\_

DATE: \_\_\_\_\_

How likely are you/your child to doze off or fall asleep in the situations described below, in contrast to feeling just tired?

This refers to your usual way of life in recent times.

Even if you/your child haven't done some of these things recently try to work out how they would have affected you/your child.

Use the following scale to choose the most appropriate number for each situation:

- 0 = would never doze
- 1 = Slight chance of dozing
- 2 = Moderate chance of dozing
- 3 = High chance of dozing

SITUATION	CHANCE OF DOZING
Sitting and reading .....	<input type="text"/>
Watching TV .....	<input type="text"/>
Sitting, inactive, in a public place (e.g., a theatre or a meeting) .....	<input type="text"/>
As a passenger in a car for an hour without a break .....	<input type="text"/>
Lying down to rest the afternoon when circumstances permit .....	<input type="text"/>
Sitting and talking to someone .....	<input type="text"/>
Sitting quietly after a lunch .....	<input type="text"/>
As a passenger in car, while stopped for a few minutes in traffic .....	<input type="text"/>
TOTAL .....	<input type="text"/>