Pediatric Airway Questionnaire

G² Dental
family dentistry

	YES	NO
1. Does your child have trouble going to bed or falling asleep?	☐	☐
2. Awaken during the night and have trouble returning to sleep?	☐	☐
3. Does he/she tend to breathe through their mouth during the day or during sleep?	☐	☐
4. Have dry mouth or bad breath upon waking in the morning?	☐	☐
5. Have you noticed or been told of any of the following while your child is sleeping?		
a. Snoring, heavy or loud breathing?	☐	☐
b. Break or pause in breathing?	☐	☐
c. Gasp, choke, or struggle to breathe?	☐	☐
d. Restless or agitated sleep? Grinding teeth?	☐	☐
e. Abnormal head posture (hyper-extension, etc.)?	☐	☐
f. Excessive sweating?	☐	☐
g. Wetting the bed?	☐	☐
6. Have you noticed any of the following during the day?		
a. Difficulty waking?	☐	☐
b. Wakes with headaches?	☐	☐
c. Groggy, tired or "out of it"?	☐	☐
d. Hyperactive?	☐	☐
e. Teachers commented?	☐	☐
7. Child often:		
a. Does not seem to listen when spoken to directly?	☐	☐
b. Has difficulty organizing tasks?	☐	☐
c. Easily distracted by extraneous stimuli?	☐	☐
d. Fidgets with hands or feet or squirms in seat?	☐	☐
e. Interrupts or intrudes on others?	☐	☐
8. Is your child frequently sick, have a history of sore throat, ear infections, sinus infections, or allergies?	☐	☐
9. Stop growing at a normal rate at any time since birth? Overweight?	☐	☐
10. Habits such as: pacifier / thumb sucking / lip biting / other?	☐	☐