Pediatric Sleep Questionnaire: Sleep-Disordered Breathing Subscale*

Child's Name: _____ Study ID #: _____

Person completing form: _____ Date: _____

Child's height _____ Child's weight _____

Please answer these questions regarding the behavior of your child during sleep and wakefulness. The questions apply to how your child acts in general during the past month, not necessarily during the past few days since these may not have been typical if your child has not been well.

	Yes	*No*	*Don't Know*
While sleeping does your child:			
Snore more than half the time?			
Always snore?			
Snore loudly?			
Have "heavy" or loud breathing?			
Have trouble breathing, or struggle to breathe?			
Have you ever seen your child stop breathing during the night?			
Does your child:			
Tend to breathe through the mouth during the day?			
Have a dry mouth on waking up in the morning?			
Occasionally wet the bed?			
Does your child:			
Wake up feeling unrefreshed in the morning?			
Have a problem with sleepiness during the day?			
Has a teacher or other supervisor commented that your child appears sleepy during the day?			
Is it hard to wake your child up in the morning?			
Does your child wake up with headaches in the morning?			
Did your child stop growing at a normal rate at any time since birth?			
Is your child overweight?			
This child often:			
Does not seem to listen when spoken to directly			
Has difficulty organizing tasks and activities			
Is easily distracted by extraneous stimuli			
Fidgets with hands or feet or squirms in seat			
Is "on the go" or often acts as if "driven by a motor"			
Interrupts or intrudes on others *(eg., butts into conversations or games)*			
Total:			
Risk Percentage: yes/yes + no	**%**	**Low/High**	

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