Tavarez ORTHODONTICS
Specialist in Adults and Children

Obstructive Sleep Apnea Screening

PATIENTS UNDER 18 YEARS OF AGE

Full Name:_____ **DOB:** _____

Gender: Male/Female **Ethnicity**: _____

Please answer on behalf of your child for the past month. If you don't know, check "?"

Does your child have any of the following: **Please check the box**	**Yes**	**No**	**?**
• A constant blocked or runny nose?	☐	☐	☐
• Recurrent chest infections/pneumonia?	☐	☐	☐
• An airway narrowing or abnormality?	☐	☐	☐
• A syndrome or other major health problem?	☐	☐	☐
Type:_____			
• Does your child have large tonsils?	☐	☐	☐
• Has your child had their adenoids or tonsils removed?	☐	☐	☐
While sleeping, does your child…. **Please check the box**	**Yes**	**No**	**?**
• Snore more than half the time?	☐	☐	☐
• Always snore?	☐	☐	☐
• Snore loudly?	☐	☐	☐
• Have trouble breathing, or struggle to breathe?	☐	☐	☐
• Have "heavy" or loud breathing?	☐	☐	☐
• 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 when waking up in the morning?	☐	☐	☐
• Occasionally wet the bed?	☐	☐	☐
• Wake up feeling unrefreshed in the morning?	☐	☐	☐
• Have a problem with sleepiness during the day?	☐	☐	☐
• Has a teacher commented that your child is sleepy during school?	☐	☐	☐
• 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?	☐	☐	☐
My child often…. **Please check the box**	**Yes**	**No**	**?**
• Does not seem to listen when spoken to directly	☐	☐	☐
• Has difficulty organizing task and activities	☐	☐	☐
• Is easily distracted by extraneous stimuli	☐	☐	☐
• Fidgets with hands or feet or squirms in seat	☐	☐	☐
• Is 'on the go' or often acts if 'driven by a motor'	☐	☐	☐
• Interrupts or intrudes on others (e.g butts into conversations or games)	☐	☐	☐

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