Patient's Name: _____

Today's Date: _____

Please check all symptoms pertaining to the patient:

- ☐ Enlarged tonsils/adenoids
- ☐ Grinding/clenching of the teeth
- ☐ Acid reflux
- ☐ Mouth-breathing
- ☐ Loud breathing
- ☐ Takes a long time to eat
- ☐ Bad breath/halitosis
- ☐ Tires easily
- ☐ Hyperactivity
- ☐ Aggressive behavior
- ☐ Difficulty paying attention while awake
- ☐ Poor school performance
- ☐ Irritability
- ☐ Decreased motivation
- ☐ Allergies
- ☐ Snoring
- ☐ Restless Sleep
- ☐ Difficulty staying asleep (insomnia)
- ☐ Wakes frequently at night
- ☐ Hard to wake up in the morning
- ☐ Excessive daytime sleepiness (hypersomnia)
- ☐ Gasping for air during sleep
- ☐ Episodes of no breathing (told by another person)
- ☐ Awakening with a dry mouth
- ☐ Morning headache
- ☐ Bed wetter

☐ No symptoms above apply

_____

Signature of person completing questionnaire

_____

Relationship to patient