

# Pediatric Airway Questionnaire

Please email this to [snooze@walkerdentistry.com](mailto:snooze@walkerdentistry.com)  
prior to your phone screening.

Walker Dentistry

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## PATIENT INFORMATION

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Date: \_\_\_\_\_

Parent / Guardian Name: \_\_\_\_\_

Email Address: \_\_\_\_\_ Phone: \_\_\_\_\_

## CHIEF COMPLAINT / CONCERNS

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## MEDICAL HISTORY

	Yes	No
Any medication allergies	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Seasonal allergies	<input type="checkbox"/>	<input type="checkbox"/>
Food allergies	<input type="checkbox"/>	<input type="checkbox"/>
Skin allergies	<input type="checkbox"/>	<input type="checkbox"/>
Attention concerns	<input type="checkbox"/>	<input type="checkbox"/>
Learning concerns	<input type="checkbox"/>	<input type="checkbox"/>
Speech therapy history	<input type="checkbox"/>	<input type="checkbox"/>
ENT infections	<input type="checkbox"/>	<input type="checkbox"/>
Headaches	<input type="checkbox"/>	<input type="checkbox"/>
Stomach aches	<input type="checkbox"/>	<input type="checkbox"/>
Surgical procedures	<input type="checkbox"/>	<input type="checkbox"/>

Detail any yes responses here

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

# Pediatric Airway Questionnaire

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## SLEEP & AIRWAY SCREENING

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### Pediatric Sleep Disordered Breathing Questionnaire

Please rate: 1 = Never 2 = Sometimes 3 = Often

	1	2	3
1. Mouth breathing during the day	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Mouth breathing at night	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Snoring	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Bedwetting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Night terrors	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Teeth grinding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Restless sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Waking during the night	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Night sweats	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Morning headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Digestive issues / stomach aches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Daytime drowsiness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. Hyperactivity / fidgeting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. Attention issues	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15. Academic struggles	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16. Speech issues	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
17. ENT infections	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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## HOME OBSERVATION QUESTIONNAIRE

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### DURING MEALS

- Gasp for air while eating
- Chew with mouth open
- Drink a lot while eating
- Trouble sitting still
- Puff cheeks when drinking

### WHILE TALKING

- Talks very fast
- Talks very slow
- Lisp
- Speech therapy history

### WHILE SITTING AROUND

- Mouth breathing
- Lips apart at rest
- Tongue between teeth
- Cheek resting on hand
- Noisy breathing

## ADDITIONAL COMMENTS

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## DEVELOPMENTAL & FAMILY HISTORY

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### DEVELOPMENTAL HISTORY

Breastfed or bottle fed: \_\_\_\_\_

If breastfed, how long?: \_\_\_\_\_

Pacifier used until age: \_\_\_\_\_

Finger/thumb sucking: \_\_\_\_\_

Hard to feed as baby: \_\_\_\_\_

Prone to ear infections: \_\_\_\_\_

### FAMILY HISTORY

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	Yes	No
Crowded teeth	<input type="checkbox"/>	<input type="checkbox"/>
Braces	<input type="checkbox"/>	<input type="checkbox"/>
Extractions for braces	<input type="checkbox"/>	<input type="checkbox"/>
Headgear	<input type="checkbox"/>	<input type="checkbox"/>
TMJ / jaw problems	<input type="checkbox"/>	<input type="checkbox"/>
Sleep apnea	<input type="checkbox"/>	<input type="checkbox"/>
Snoring	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>

### ADDITIONAL COMMENTS

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