Children's Airway Screener

For ages 2 -12 years old - **Preliminary form: Please note this tool has not been validated**

Name:_____ Birth Date:_____ Date:_____

Relationship to Patient: Mother ☐ Father ☐ Guardian ☐ Child's Age

Oral health has been recognized to be associated with sleep and daytime well-being.

Please fill out this questionnaire so we can address any related health issues in your child.

Directions: Please complete this form by checking "Yes", "No", or IDK ("I Don't Know") for each question.

	YES	NO	IDK
1. Other than when sick, does your child **typically** breathe with his/her **mouth open or lips apart**, either while awake or asleep?	☐	☐	☐
2. Other than when sick, does your child **SNORE** or have pauses in **breathing or STOP breathing** while sleeping, or does your child have noisy breathing or difficulty breathing while awake?	☐	☐	☐
3. While sleeping, does your child **frequently** do ANY of the following: toss and turn, kick, sleepwalk or talk in their sleep, grind or clench teeth, sleep on the stomach, kneel, or sleep with the head extended backwards/upwards?	☐	☐	☐
4. In the morning, other than when sick, does your child **frequently** have ANY of the following: difficulty waking up, nasal congestion, dry mouth, jaw pain, or headaches?	☐	☐	☐
5. Does your child **frequently** have **ANY** of the following: unusual sleepiness or tiredness during the day, difficulty sitting still, concentrating, or problems with behaviors, emotions or poor school performance.	☐	☐	☐

6. **How hard was it for you to complete this form**? Easy ☐ Average ☐ Difficult ☐ If difficult Why?

_____

7. **How much time did it take you to complete this form**?

5 minutes or less a 6-10 minutes ☐ 11-15 minutes ☐ > 16 minutes ☐

If you would like to discuss the results of this questionnaire, please send your e-mail address and cell# to 127ivyroad@gmail.com so that we can schedule a Zoom consultation.