Oregon Ear, Nose & Throat Center
541-779-7331

Quality of Life/Pediatric Sleep Survey

Patient Name _____ DOB _____ Date _____

SCORE: (81+ Severe)

	Never	Hardly ever	A little of the time	Some of the time	A good bit of the time	Most of the time	All of the time
Sleep Disturbance							
During the past four weeks, how often has your child had...							
Loud snoring?	1	2	3	4	5	6	7
Breath holding spells or pauses in breathing at night?	1	2	3	4	5	6	7
Choking or gasping sounds while asleep?	1	2	3	4	5	6	7
Restless sleep or frequent awakening?	1	2	3	4	5	6	7
Physical Symptoms							
During the past four weeks, how often has your child had...							
Mouth breathing because of nasal congestion?	1	2	3	4	5	6	7
Frequent colds or upper respiratory infections?	1	2	3	4	5	6	7
Nasal discharge or runny nose?	1	2	3	4	5	6	7
Emotional Symptoms							
During the past four weeks, how often has your child had...							
Mood swings or temper tantrums?	1	2	3	4	5	6	7
Aggressive or hyperactive behavior?	1	2	3	4	5	6	7
Discipline problems?	1	2	3	4	5	6	7
Daytime Function							
During the past four weeks, how often has your child had...							
Excessive daytime sleepiness?	1	2	3	4	5	6	7
Poor attention span or concentration?	1	2	3	4	5	6	7
Difficulty getting up in the morning?	1	2	3	4	5	6	7
Caregiver Concerns							
During the past four weeks, how often have the problems above...							
Caused you to worry about your child's general health?	1	2	3	4	5	6	7
Created concern that your child is not getting enough air?	1	2	3	4	5	6	7
Interfered with your ability to perform daily activities?	1	2	3	4	5	6	7
Made you frustrated?	1	2	3	4	5	6	7

Name of person completing this form: _____ Relationship: _____