PEDIATRIC AIRWAY EVALUATION

Problem	No	Yes	If Yes, Age of Onset	If Yes, Days per week
a. Snoring or Noisy Breathing				
b. Choking and Gasping in Sleep				
c. Stopping Breathe				
d. Struggling to Breathe				
e. Mouth Breathing/Trouble Breathing Through Nose				
f. Difficulty Swallowing/Drooling				
g. Restless Sleep/Tossing and Turning				
h. Frequent Leg Movements				
i. Teeth Grinding				
j. Sleep Walking				
k. Body Rocking/Head Banging				
l. Awakening Frightened/Screaming				
m. Bed Wetting				
n. Night Sweating				

Does your child have any of these problems?

Problem	No	Yes	If Yes, Age of Onset
a. Enlarged Tonsils	☐	☐	
b. Enlarged Adenoids	☐	☐	
c. Nasal Allergies/Hay fever	☐	☐	
d. Asthma	☐	☐	
e. Frequent cold/Sore Throat	☐	☐	
f. Frequent Ear Infections	☐	☐	
g. Frequent Morning Headaches	☐	☐	
h. Excessive Weight Gain	☐	☐	
i. Failure to Gain Weight	☐	☐	
j. Stomach Acid Reflux	☐	☐	
k. Neurologic or Muscular Disorder	☐	☐	
l. Genetic Disease	☐	☐	
m. Craniofacial Disorder	☐	☐	
n. Developmental Disability	☐	☐	
o. Hyperactivity	☐	☐	
p. Difficulties Paying Attention	☐	☐	
q. Irritability or Mood Swings	☐	☐	
r. Recent Decrease in School Performance	☐	☐	
s. Frequent Leg Pain or Discomfort	☐	☐	
t. Frequent Rubbing of Legs	☐	☐	
Any Other Diagnosed Abnormalities	☐	☐	

SUBMIT