Myosleep Kids Questionnaire

Patient Name:	
DOB:	Date:

Please answer the following questions based on your child's average sleep habits/quality during the past month. If you are unsure about an answer to a question, please tick the '?' column.

1. Going To Sleep	**Yes**	**No**	**?**
Does your child have any problems going to bed or falling asleep?			
Does your child tend to have an irregular bedtime?			
Does your child tend to have an irregular wake time?			
Does your child's bedtime/wake time differ greatly between weekdays and weekends?			

2. While Sleeping	**Yes**	**No**	**?**
Does your child wake up often during the night after falling asleep?			
Does your child have their mouth open while sleeping?			
Does your child have heavy or loud breathing habits while asleep?			
Does your child snore for more than half of the night's sleep duration?			
Does your child snore for more than three or four nights out of the week?			
Does your child snore every night?			
Does your child snore loudly?			
Does your child have difficulty breathing at night while sleeping?			
Does your child ever stop breathing while sleeping?			
Does your child have regular nightmares, sleep walk or have any other unusual sleep behaviours?			
Does your child occasionally wet the bed?			

3. While Awake	**Yes**	**No**	**?**
Does your child have a dry mouth when they wake up in the morning?			
Does your child find it difficult to wake in the morning?			
Does your child wake up feeling unrefreshed in the morning?			
Does your child seem overly tired or take excessive naps during the day for their age?			
Does your child wake up with headaches in the morning?			
Do you think your child is failing to get enough sleep for his/her age?			
Has a teacher or other supervisor commented that your child appears unusually sleepy during the day?			
Does your child tend to breathe through the mouth while awake?			
Is your child's overall growth slower than the average child for their age?			
Is your child overweight?			
Does your child have difficulty organising tasks and activities for their age?			
Does your child appear to not listen when spoken to directly?			
Does your child get easily distracted, fidget or struggle to sit still?			
Is your child hyperactive?			

Please provide any additional feedback that may be relevant to your child's sleep habits: _____

Parent Name/s: _____ Parent Signature: _____