



CHILDREN SNORING

Patient's Name _____ SSN _____

Mailing Address _____

City, State, Zip _____

Parents Marital Status S M W D Birthdate _____ Age _____

Phone (h) _____ Phone (c) _____ Phone (w) _____

Email Address _____

Please answer the following questions by checking "Yes" or "No"

Does your child...

- 1. Snore? [] Yes [] No
2. Breathe through the mouth? [] Yes [] No
3. Pause in breathing at night? [] Yes [] No
4. Stop breathing? [] Yes [] No
5. Gasp for breath? [] Yes [] No
6. Struggle to breathe? [] Yes [] No
7. Restless sleep? [] Yes [] No
8. Sleep in an unusual sleeping position? [] Yes [] No
9. Extend neck while sleeping? [] Yes [] No
10. Frequently awoken during sleep? [] Yes [] No
11. Persistent stuffy nose? [] Yes [] No
12. Early morning headaches? [] Yes [] No
13. Impaired memory and/or concentration? [] Yes [] No
14. Learning difficulties? [] Yes [] No
15. Attention disorders? [] Yes [] No
16. Wet the bed (if over the age of 4)? [] Yes [] No
17. Difficulty awaking in the morning? [] Yes [] No
18. Perspire during sleep? [] Yes [] No
19. Daytime sleepiness or fatigue? [] Yes [] No
20. Choking? [] Yes [] No
21. Hyperactivity? [] Yes [] No
22. Aggressive behavior? [] Yes [] No
23. Irritable behavior? [] Yes [] No
24. Antisocial behavior? [] Yes [] No
25. Picky eater? [] Yes [] No
26. Overweight? [] Yes [] No
27. Underweight? [] Yes [] No

PLEASE RETURN COMPLETED FORM TO ONE OF THE FOLLOWING

Email to: zrobinson@entsavannah.com

Ear, Nose & Throat Associates of Savannah, P.C. 5201 Frederick Street Savannah, GA 31405

Fax to: 912.351.3039