

Oregon Ear, Nose and Throat Center

Quality of Life/Pediatric Sleep Survey

Patient Name _____ DOB: _____ Date: _____

None of the time	Hardly any of the time	A little of the time	Some of the time	A good bit of the time	Most of the time	All of the time
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Sleep Disturbance

During the past 4 weeks, how often has your child had...

- ...Loud Snoring?
- ...Breath-holding spells or pauses in breathing at night?
- ...Choking or making gasping sounds while asleep?
- ...Restless sleep or frequent awakening?

1	2	3	4	5	6	7
1	2	3	4	5	6	7
1	2	3	4	5	6	7
1	2	3	4	5	6	7

Physical Symptoms

During the past 4 weeks, how often has your child had...

- ...Mouth breathing because of nasal congestion?
- ...Frequent colds or upper respiratory infections?
- ...Nasal discharge or runny nose?
- ...Difficulty swallowing?

1	2	3	4	5	6	7
1	2	3	4	5	6	7
1	2	3	4	5	6	7
1	2	3	4	5	6	7

Emotional Symptoms

During the past 4 weeks, how often has your child had...

- ...Mood swings or temper tantrums?
- ...Aggressive or hyperactive behavior?
- ...Discipline problems?

1	2	3	4	5	6	7
1	2	3	4	5	6	7
1	2	3	4	5	6	7

Daytime Function

During the past 4 weeks, how often has your child had...

- ... Excessive daytime sleepiness?
- ...Poor attention span or concentration?
- ...Difficulty getting up in the morning?

1	2	3	4	5	6	7
1	2	3	4	5	6	7
1	2	3	4	5	6	7

Caregiver Concerns

During the past 4 weeks, how often have the problems above...

- ...Caused you to worry about your child's general health?
- ...Created concern that your child is not getting enough air?
- ...Interfered with your ability to perform daily activities?
- ...Made you frustrated?

1	2	3	4	5	6	7
1	2	3	4	5	6	7
1	2	3	4	5	6	7
1	2	3	4	5	6	7

Name of person and relationship to patient completing this form? _____

<p>SCORE _____</p> <p>0-60 small impact on health-related quality of life</p> <p>60-80 moderate impact</p> <p>80+ severe impact</p>
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