Laser Revision New Patient Questionnaire (Child)

Patient's Name: _____ DOB _____ Gender_____

Evaluation for sleep disordered breathing: Sleep deprived children suffer many of these symptoms due to compromised airway opening. This can result in reduced oxygen, air flow and increased carbon dioxide, swollen tonsils and adenoids, orthodontic problems, brain and immune systems problems. A tongue restriction (tie) can be a contributing factor or the direct cause!

1. _____ Your child uses or used a pacifier for more than 6 months of age
2. _____ Your child successfully was able to breast/chestfeed. How long _____
3. _____ Your child bottle feed exclusively
4. _____ Your child bottle fed until age ___
5. _____ Your child has primarily a soft diet

Please indicate the degree of any problems by choosing from the following symptoms severity
0 = not a problem 1 = occasionally 2= moderate 3= significan

1. ___ Snoring during the night
2. ___ Mouth breathing when sleeping
3. ___ Mouth breathing during the day
4. ___ Wakes up frequently at night
5. ___ Wanders all over the bed at night
6. ___ Sleeps in the teepee position
7. ___ Grind their teeth at night
8. ___ Restless sleeper
9. ___ Talks in their sleep
10. ___ Signs or diagnosis of hyperactivity
11. ___ Falls asleep watching TV
12. ___ wakes up in the morning with a headache
13. ___ Does poorly in school
14. ___ Diagnosis of ADD or ADHD
15. ___ Taking any medications for behavior modification
16. ___ Aggressive behavior
17. ___ Irritability and/or anger
18. ___ Has had multiple throat infections
19. ___ Gags on foods
20. ___ Is a picky eater
21. ___ Dark circles under their eyes
22. ___ Fidgets with their hands
23. ___ Bedwetting
24. ___ Excessive sweating during night
25. ___ Sleep apnea
26. ___ Delayed or stunted growth
27. ___Sleep walking
28. ___ Food and texture aversions
29. ___ Acid reflux
30. ___ Gap between front teeth

Speech questionnaire

1. ____Do you have a hard time understanding your child's speech?
2. ____ Do other people have a difficult time Understanding your child's speech?
3. ____ Does your child speak with a lisp?
4. ____ Does your child get upset or frustrated When others cannot understand them when they speak?
5. ____ Does your child speak with a nasal tone?
6. ____ Does your child speak with hoarseness?
7. ____ Does your child have delayed speech?
8. ____ Has your child received any Speech therapy? If so, how long? _____

Does your child have any medical conditions? _____
Does your child have a bleeding disorder?_____
Is your child taking any medications? Yes___ No___ (please list medication(s)
_____
Who referred you to our office? _____

Has your child been evaluated for ties? Yes___ No___ If yes, by who? _____
Child's Physician: _____ Phone number: _____
Can we send a report to the physician? Yes___ No ___ please initial _____