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
Sleep Disturbance							
During the past 4 weeks, how often has your child had..							
Loud snoring?	1	2	3	4	5	6	7
Breath holding spells or pauses in breathing at night?	1	2	3	4	5	6	7
Choking or making gasping sounds while asleep?	1	2	3	4	5	6	7
Restless sleep or frequent awakening?	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?	1	2	3	4	5	6	7
Frequent colds or upper repiratory infections?	1	2	3	4	5	6	7
Nasal discharge or runny nose?	1	2	3	4	5	6	7
Difficulty swallowing?	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?	1	2	3	4	5	6	7
Aggressive or hyperactive behavior?	1	2	3	4	5	6	7
Discipline problems?	1	2	3	4	5	6	7
Daytime Function							
During the past 4 weeks, how often has your child had..							
Excessive daytime sleepiness?	1	2	3	4	5	6	7
Poor attention span or concentration?	1	2	3	4	5	6	7
Difficulty getting up in the morning?	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 general health?	1	2	3	4	5	6	7
Created concern that your child is not getting enough air	1	2	3	4	5	6	7
Interfered with your ability to perform daily activities?	1	2	3	4	5	6	7
Made you frustrated?	1	2	3	4	5	6	7

Name of person completing this form: _____

Relationship: _____

SCORE: _____

Impact on health related quality of life

0-61	Small
60-81	Moderate
81 +	Severe