The Royal Children's Hospital Melbourne

OSA questionnaire

NAME: ______________________________ DATE: ____________________

For each question below please circle the number that best describes how often each symptom or problem has occurred during the last 4 weeks. Please circle only one number per question. Thank you.

		None of the time	**Some of the time**	**Most of the time**	**All of the time**
	During the past 4 weeks, how often has your child had…				
1	Loud snoring?	0	1	2	3
2	Breath holding spells or pauses in breathing at night?	0	1	2	3
3	Choking or made gasping sounds while asleep?	0	1	2	3
4	Mouth breathing because of a blocked nose?	0	1	2	3
5	Frequent colds or a runny nose?	0	1	2	3
6	Nasal discharge or a runny nose?	0	1	2	3
7	Aggressive or hyperactive behaviour?	0	1	2	3
8	Discipline problems?	0	1	2	3
9	Excessive daytime sleepiness?	0	1	2	3
10	Poor attention span or concentration?	0	1	2	3
11	Breathing problems during sleep that made you worried that they were not getting enough air?	0	1	2	3