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| **Sleep Apnea - Child** |
| **Protocol Id:** | 91502 |
| **Description of Protocol** | See the protocol section for how to access this protocol |
| **Specific Instructions** | The Pediatric Sleep Questionnaire (PSQ) is a proprietary questionnaire. See protocol section for how to obtain the questionnaire. |
| **Protocol:** |

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| 1. Today’s Date: Month Day Year |
| 2. Where are you completing this questionnaire?  |
| 3. Date of Child’s Birth: Month Day Year |
| 4. Sex: Male or Female?  |
| 5. Current Height (feet/inches):  |
| 6. Current Weight (pounds):  |
| 7. Grade in school (if applicable):  |
| 8. Racial/Ethnic Background of your Child (please circle):1.) American Indian 2.) Asian-American3.) African-American 4.) Hispanic5.) White/not Hispanic 6.) Other or unknown |

|  |  |
| --- | --- |
| A. Nighttime and sleep behavior:9. WHILE SLEEPING, DOES YOUR CHILD ... |    |
| ... ever snore? | Y N DK |
| ... snore more than half the time? | Y N DK |
| ... always snore? |   Y N DK |
| ... snore loudly? | Y N DK |
| ... have "heavy" or loud breathing? | Y N DK |
| ... have trouble breathing, or struggle to breathe?**10. HAVE YOU EVER ...** | Y N DK |
| ... seen your child stop breathing during the night?If so, please describe what has happened: | Y N DK |
| ... been concerned about your child’s breathing during sleep? | Y N DK |
| ... had to shake your sleeping child to get him or her to breathe, or wake up and breathe? | Y N DK |
| ... seen your child wake up with a snorting sound?**11. DOES YOUR CHILD ...** | Y N DK |
| ... have restless sleep? | Y N DK |
| ... describe restlessness of the legs when in bed?... have "growing pains" (unexplained leg pains)?... have "growing pains" that are worst in bed?**12. WHILE YOUR CHILD SLEEPS, HAVE YOU SEEN ...** | Y N DKY N DKY N DK |
| ... brief kicks of one leg or both legs?... repeated kicks or jerks of the legs at regular intervals (i.e., about every 20 to 40 seconds)?**13. AT NIGHT, DOES YOUR CHILD USUALLY ...** | Y N DKY N DK |
| ... become sweaty, or do the pajamas usually become wet with perspiration? | Y N DK |
| ... get out of bed (for any reason)? | Y N DK |
| ... get out of bed to urinate?If so, how many times each night, on average? | Y N DK\_\_\_\_\_\_\_times |
| **14. Does your child usually sleep with the mouth open?** | Y N DK |
| **15. Is your child’s nose usually congested or "stuffed" at night?** | Y N DK |
| **16. Do any allergies affect your child’s ability to breathe through the nose?****17. DOES YOUR CHILD ...** | Y N DK |
| ... tend to breathe through the mouth during the day? | Y N DK |
| ... have a dry mouth on waking up in the morning? | Y N DK |
| ... complain of an upset stomach at night? | Y N DK |
| ... get a burning feeling in the throat at night? | Y N DK |
| ... grind his or her teeth at night? | Y N DK |
| ... occasionally wet the bed? | Y N DK |
| 18. Has your child ever walked during sleep ("sleep walking")? | Y N DK |
| 19. Have you ever heard your child talk during sleep ("sleep talking")? | Y N DK |
| 20. Does your child have nightmares once a week or more on average? | Y N DK |
| 21. Has your child ever woken up screaming during the night? | Y N DK |
| 22. Has your child ever been moving or behaving, at night, in a way that made you think your child was neither completely awake nor asleep?If so, please describe what has happened: | Y N DK |
| 23. Does your child have difficulty falling asleep at night? | Y N DK |
| 24. How long does it take your child to fall asleep at night? (a guess is O.K.) | \_\_\_\_\_\_\_\_ minutes |
| 25. At bedtime does your child usually have difficult "routines" or "rituals," argue a lot, or otherwise behave badly? | Y N DK |
| **26. DOES YOUR CHILD ...**... bang his or her head or rock his or her body when going to sleep? | Y N DK |
| ... wake up more than twice a night on average? | Y N DK |
| ... have trouble falling back asleep if he or she wakes up at night? | Y N DK |
| ... wake up early in the morning and have difficulty going back to sleep? | Y N DK |
| 27. Does the time at which your child goes to bed change a lot from day to day? | Y N DK |
| 28. Does the time at which your child gets up from bed change a lot from day to day?**29. WHAT TIME DOES YOUR CHILD USUALLY ...** | Y N DK |
| ... go to bed during the week? |    |
| ... go to bed on the weekend or vacation? |    |
| ... get out of bed on weekday mornings? |    |
| ... get out of bed on weekend or vacation mornings? |    |
| B. Daytime behavior and other possible problems:30. DOES YOUR CHILD ...  |
| ... wake up feeling unrefreshed in the morning? | Y N DK |
| ... have a problem with sleepiness during the day? | Y N DK |
| ... complain that he or she feels sleepy during the day? | Y N DK |
| 31. Has a teacher or other supervisor commented that your child appears sleepy during the day? | Y N DK |
| 32. Does your child usually take a nap during the day? | Y N DK |
| 33. Is it hard to wake your child up in the morning? | Y N DK |
| 34. Does your child wake up with headaches in the morning? | Y N DK |
| 35. Does your child get a headache at least once a month, on average? | Y N DK |
| 36. Did your child stop growing at a normal rate at any time since birth?If so, please describe what happened: | Y N DK |
| 37. Does your child still have tonsils?If not, when and why were they removed?:**38. HAS YOUR CHILD EVER ...** | Y N DK |
| ... had a condition causing difficulty with breathing?If so, please describe: | Y N DK |
| ... had surgery?If so, did any difficulties with breathing occur before, during, or after surgery? | Y N DKY N DK |
| ... become suddenly weak in the legs, or anywhere else, after laughing or being surprised by something? | Y N DK |
| ... felt unable to move for a short period, in bed, though awake and able to look around? | Y N DK |
| 39. Has your child felt an irresistible urge to take a nap at times, forcing him or her to stop what he or she is doing in order to sleep? | Y N DK |
| 40. Has your child ever sensed that he or she was dreaming (seeing images or hearing sounds) while still awake? | Y N DK |
| 41. Does your child drink caffeinated beverages on a typical day (cola, tea, coffee)?If so, how many cups or cans per day? | Y N DK\_\_\_\_\_\_\_ cups |
| 42. Does your child use any recreational drugs?If so, which ones and how often? | Y N DK |
| 43. Does your child use cigarettes, smokeless tobacco, snuff, or other tobacco products? If so, which ones and how often? | Y N DK |
| 44. Is your child overweight?If so, at what age did this first develop? | Y N DK\_\_\_\_\_\_ years |
| 45. Has a doctor ever told you that your child has a high-arched palate (roof of the mouth)? | Y N DK |
| 46. Has your child ever taken Ritalin (methylphenidate) for behavioral problems? | Y N DK |
| 47. Has a health professional ever said that your child has attention-deficit disorder (ADD) or attention-deficit/hyperactivity disorder (ADHD)? | Y N DK |

C. Other Information 48. If you are currently at a clinic with your child to see a physician, what is the problem that brought you?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_49. If your child has long-term medical problems, please list the three you think are most significant.1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_-2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_3.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_50. Please list any medications your child currently takes:

|  |  |  |  |
| --- | --- | --- | --- |
| Medicine | Size (mg) or amount per dose | Taken how often? | Dates Taken |
| \_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_ |
| Effect: |  |  |  |
| \_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_ |
| Effect: |  |  |  |
| \_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_ |
| Effect: |  |  |  |
| \_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_ |
| Effect: |  |  |  |

51. Please list any medication your child has taken in the past if the purpose of the medication was to improve his or her behavior, attention, or sleep:

|  |  |  |  |
| --- | --- | --- | --- |
| Medicine | Size (mg) or amount per dose | Taken how often? | Dates Taken |
| \_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_ |
| Effect: |  |  |  |
| \_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_ |
| Effect: |  |  |  |
| \_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_ |
| Effect: |  |  |  |
| \_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_ |
| Effect: |  |  |  |

52. Please list any sleep disorders diagnosed or suspected by a physician in your child. For each problem, please list the date it started and whether or not it is still present.

|  |  |  |
| --- | --- | --- |
| Sleep Disorder | Date Started | Still Present |
|  |  | Y N |
|  |  | Y N |
|  |  | Y N |
|  |  | Y N |

53. Please list any psychological, psychiatric, emotional, or behavioral problems diagnosed or suspected by a physician in your child. For each problem, please list the date it started and whether or not it is still present.

|  |  |  |
| --- | --- | --- |
| Problem | Date Started | Still Present |
|  |  | Y N |
|  |  | Y N |
|  |  | Y N |
|  |  | Y N |

54. Please list any sleep or behavior disorders diagnosed or suspected in *your child’s* brothers, sisters, or parents:

|  |  |
| --- | --- |
| Relative | Condition |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

D. Additional Comments:Please use the space below to print any additional comments you feel are important. Please also use this space to describe details regarding any of the above questions.Instructions: 55. Please indicate, by checking the appropriate box, how much each statement\* applies to this child:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| This child often... | Does not apply0 | Applies just a little1 | Applies quite a bit2 | Definitely applies most of the time3 |
| ... does not seem to listen when spoken to directly. |  |  |  |  |
| ... has difficulty organizing tasks and activities. |  |  |  |  |
| ... is easily distracted by extraneous stimuli. |  |  |  |  |
| ... fidgets with hands or feet or squirms in seat. |  |  |  |  |
| ... is "on the go" or often acts as if "driven by a motor." |  |  |  |  |
| ... interrupts or intrudes on others (e.g., butts into conversations or games.) |  |  |  |  |

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| **Selection Rationale** | This protocol was chosen because of its validation in several age groups of children, because of its relative ease of administration, and because it can be used in large cohorts. |
| **Source** | University of Michigan, Pediatric Sleep Questionnaire, Version 070424 |
| **Language** | English |
| **Participant** | Parents of children ages 2 to 18 |
| **Personnel and Training Required** | None |
| **Equipment Needs** | None |
| **Standards:** |

|  |  |  |  |
| --- | --- | --- | --- |
| **Standard** | **Name** | **ID** | **Source** |
| Common Data Element (CDE) | Person Sleep Apnea Text | 2970224 | [CDE Browser](https://cdebrowser.nci.nih.gov/CDEBrowser/search?elementDetails=9&FirstTimer=0&PageId=ElementDetailsGroup&publicId=2970224&version=1.0) |
| Logical Observation Identifiers Names and Codes (LOINC) | Resp sleep apnea child proto | 62637-4 | [LOINC](http://s.details.loinc.org/LOINC/62637-4.html?sections=Web) |

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| **General references** | Chervin, R. D., Hedger, K., Dillon, J. E., & Pituch, K. J. (2000). Pediatric Sleep Questionnaire (PSQ): Validity and reliability of scales for sleep-disordered breathing, snoring, sleepiness, and behavioral problems. Sleep Medicine, 1, 21-32.Chervin, R. D., Weatherly, R. A., Garetz, S. L., Ruzicka, D. L., Giordani, B. J., Hodges, E. K., Dillon, J. E., & Guire, K. E. (2007). Pediatric Sleep Questionnaire: Prediction of sleep apnea and outcomes. Archives of Otolaryngology-Head & Neck Surgery, 133, 216-222. |
| **Protocol Type** | Self-administered questionnaire |
| **Derived Variables** | None |
| **Requirements** |

|  |  |
| --- | --- |
| **Requirement Category** | **Required** |
| Major equipmentThis measure requires a specialized measurement device that may not be readily available in every setting where genome wide association studies are being conducted. Examples of specialized equipment are DEXA, Echocardiography, and Spirometry | No |
| Specialized trainingThis measure requires staff training in the protocol methodology and/or in the conduct of the data analysis. | No |
| Specialized requirements for biospecimen collectionThis protocol requires that blood, urine, etc. be collected from the study participants. | No |
| Average time of greater than 15 minutes in an unaffected individualAverage time of greater than 15 minutes in an unaffected individual | No |

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| **Process and Review:** | [Expert Review Panel #6](http://phenx.org/node/118) (ERP 6) reviewed the measures in the Respiratory domain. Guidance from the ERP 6 includes:• Link to proprietary protocol providedBack-compatible: no changes to Data Dictionary Previous version in Toolkit archive ([link](https://www.phenxtoolkit.org/index.php?pageLink=browse.archive.protocols&id=90000)) |