## Pediatric Airway Assessment

This screening form may help identify patients at increased risk for sleep-related breathing disorders (e.g., obstructive sleep apnea) and/or breathing complications when undergoing sedation or general anesthesia. Such patients may benefit from referral to a medical professional for further evaluation and management.

Patient name:				Birthdate	e:	/	,	_/		Ger	nder:
Part I. General history											
Was your child born prematurely? □	NO	□ Y	ES	(how man	iy we	eks e	arly?):				
Does your child have a craniofacial syndrome?	NO NO	☐ Y	ES	(describe)	:						
Does your child have any history of:											
1 / 0 1	NO NO										
	NO										
1 / 01	NO NO										
repeated exposure to smoke:	NO	<b>–</b> 1	ĿS	(describe):							
Part II. Daytime indicators											
Does your child often:											
tend to breathe through the mouth?							NO		YES		Do not know
wake up with headaches in the morning?							NO		YES		Do not know
seem restless, unable to sit still, or always on the			•1	C 15	,		NO		YES		Do not know
interrupt others, have difficulty staying focused,			•	rrustratea:			NO		YES		Do not know
Do you or a teacher notice your child appears sleep	y durii	ng the c	lay:			ч	NO	Ч	YES	ч	Do not know
Part III. Sleep history											
How would you rate your child's sleep?	ood	☐ Fa	air	☐ Poo	r						
How many hours does your child sleep on average	during	a 24-h	our	period?: _							
Does your child:											
fall asleep quickly?				□ NO		YES		Do n	ot knov	V	
snore more than half the time while sleeping?					□ Y	YES		Do n	ot knov	V	
snore loudly while sleeping?  have trouble breathing or struggle to breathe while asleep?								Do n	ot knov	V	
have trouble breathing or struggle to breathe while asleep?									ot knov		
stop breathing during sleep?				□ NO					ot knov		
grind his/her teeth while sleeping?	1	15		□ NO					ot knov		
sleep in a seated position or with neck hypere	xtende	ed:		□ NO					ot knov		
occasionally wet the bed at night? experience excessive sweating while sleeping?				□ NO					ot knov ot knov		
Is your child hard to wake up in the morning?				□ NO	<u> </u>	ı E3	u	Do n	ot knov	V	
Signature of parent/guardian	 I	Relation	ship	to child					Date		

This sample form, developed by the American Academy of Pediatric Dentistry, is provided as a practice tool for pediatric dentists and other dentists treating children. It was developed by experts in pediatric dentistry and is offered to facilitate excellence in practice. However, this form does not establish or evidence a standard of care. In issuing this form, the American Academy of Pediatric Dentistry is not engaged in rendering legal or other professional advice. If such services are required, competent legal or other professional counsel should be sought.

Part IV: Clinical assessmen	nt				
Does the patient appear or	verweight? 🔲 NO	☐ YES	BMI	Percentile _	
Does the patient have limited neck mobility? micro/retrognathia? limited oral opening? lip incompetency? an anterior open bite? a narrow maxillary arch a posterior crossbite? macroglossia?	n with vaulted palate?	<ul><li>□ NO</li><li>□ NO</li><li>□ NO</li><li>□ NO</li><li>□ NO</li><li>□ NO</li><li>□ NO</li><li>□ NO</li></ul>	YES		
Which Modified Mallamp	oati Classification¹ best	describes th	ne patient?	□ I □ II	□ III □ IV
			E		IV
XXZI • 1 • 11 1 1 / 1	1/1 1 1 1				2 5 /
Which tonsillar grade <sup>1</sup> (ad	apted) best describes th	ne patient?		1 • 2 •	3 • 4
				Y	
0 Surgically removed	1 Tonsils hidden	2 Tonsils ex		3 Tonsils are beyo	
tonsils	within tonsil pillars	to the	pillars	the pillars	to midline
Is a medical referral indicate	ted?	ES			
Comments:					
		- 1	Doctor's signatu	Date	
Reference:					

1. Friedman M, Tanyeri H, La Rosa M, et al. Clinical predictors of obstructive sleep apnea. Laryngoscope 1999;109(12):1901-7.