

# 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: \_\_\_\_/\_\_\_\_/\_\_\_\_ Gender: \_\_\_\_\_

## Part I. General history

- Was your child born prematurely?  NO  YES (how many weeks early?): \_\_\_\_\_
- Does your child have a craniofacial syndrome?  NO  YES (describe): \_\_\_\_\_
- Does your child have any history of:
- a physical or neurological impairment?  NO  YES (describe): \_\_\_\_\_
  - low muscle tone?  NO  YES (describe): \_\_\_\_\_
  - respiratory disease/breathing problems?  NO  YES (describe): \_\_\_\_\_
  - repeated exposure to smoke?  NO  YES (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 go”?  NO  YES  Do not know
  - interrupt others, have difficulty staying focused, or become easily frustrated?  NO  YES  Do not know
- Do you or a teacher notice your child appears sleepy during the day?  NO  YES  Do not know

## Part III. Sleep history

- How would you rate your child’s sleep?  Good  Fair  Poor
- How many hours does your child sleep on average during a 24-hour period?: \_\_\_\_\_
- Does your child:

- fall asleep quickly?  NO  YES  Do not know
  - snore more than half the time while sleeping?  NO  YES  Do not know
  - snore loudly while sleeping?  NO  YES  Do not know
  - have trouble breathing or struggle to breathe while asleep?  NO  YES  Do not know
  - stop breathing during sleep?  NO  YES  Do not know
  - grind his/her teeth while sleeping?  NO  YES  Do not know
  - sleep in a seated position or with neck hyperextended?  NO  YES  Do not know
  - occasionally wet the bed at night?  NO  YES  Do not know
  - experience excessive sweating while sleeping?  NO  YES  Do not know
- Is your child hard to wake up in the morning?  NO  YES  Do not know

\_\_\_\_\_  
Signature of parent/guardian

\_\_\_\_\_  
Relationship 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.*

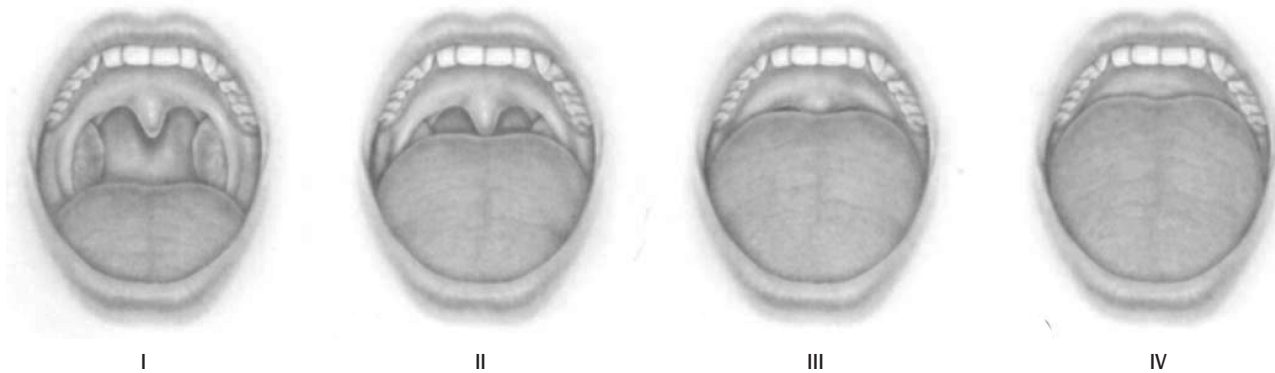
**Part IV: Clinical assessment**

Does the patient appear overweight?  NO  YES BMI \_\_\_\_\_ Percentile \_\_\_\_\_

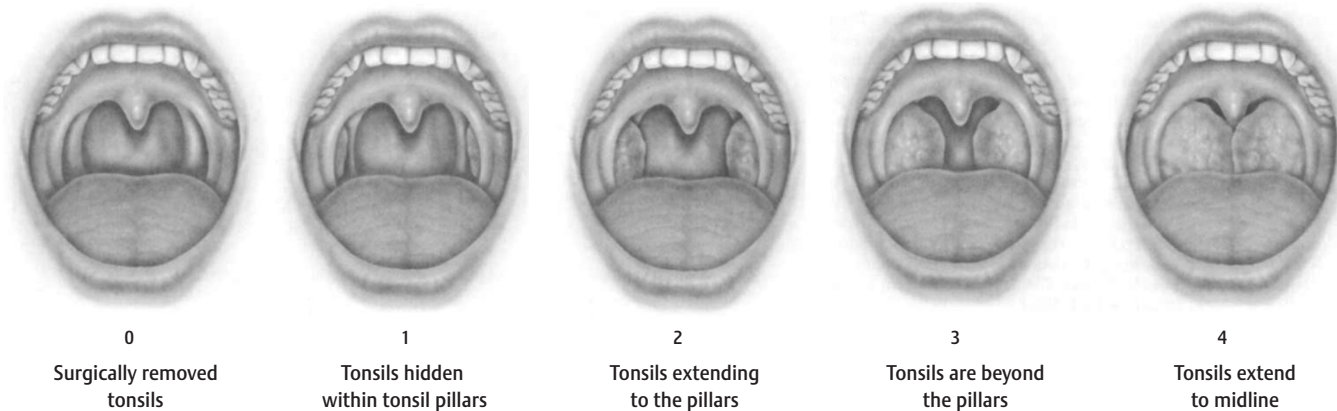
Does the patient have

- limited neck mobility?  NO  YES
- micro/retrognathia?  NO  YES
- limited oral opening?  NO  YES
- lip incompetency?  NO  YES
- an anterior open bite?  NO  YES
- a narrow maxillary arch with vaulted palate?  NO  YES
- a posterior crossbite?  NO  YES
- macroglossia?  NO  YES

Which Modified Mallampati Classification<sup>1</sup> best describes the patient?  I  II  III  IV



Which tonsillar grade<sup>1</sup> (adapted) best describes the patient?  0  1  2  3  4



Is a medical referral indicated?  NO  YES

Comments: \_\_\_\_\_

\_\_\_\_\_  
Doctor's signature

\_\_\_\_\_  
Date

**Reference:**

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

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