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.

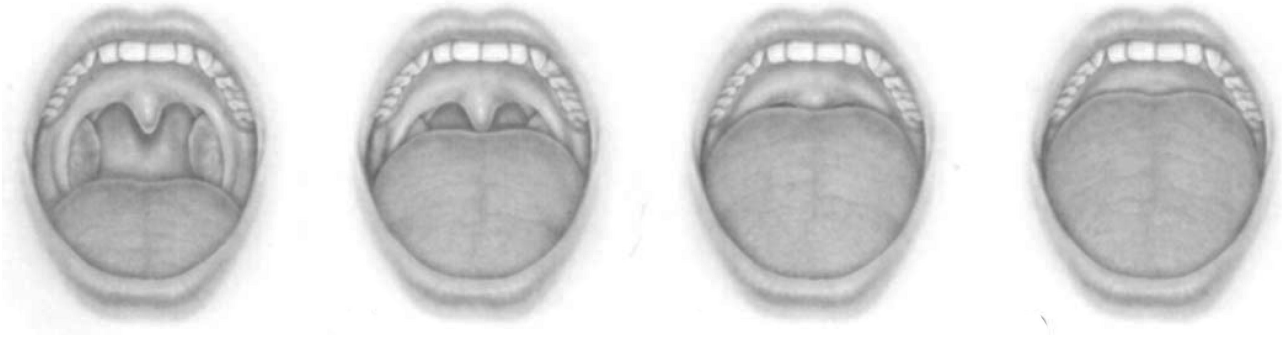
Part IV: Clinical assessment

Does the patient appear overweight? ❑ NO ❑ YES BMI _____ Percentile _____

Does the patient have

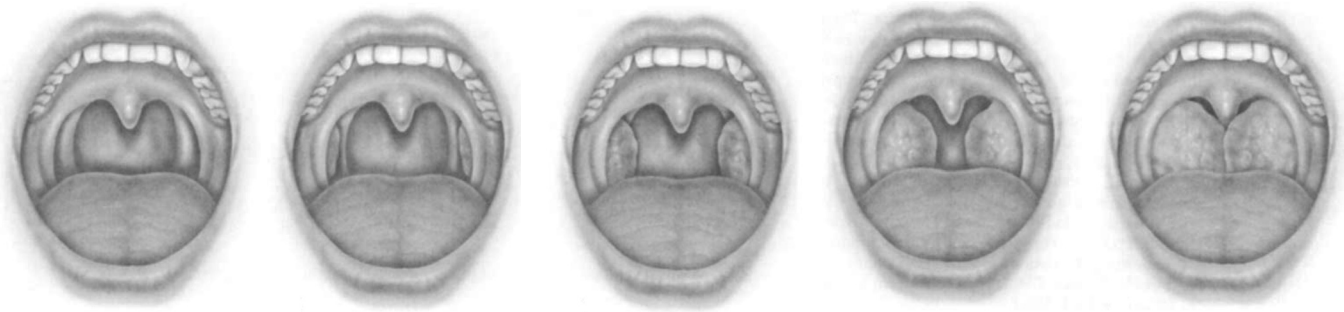
limited neck mobility?	❑ NO	❑ YES
micro/retrognathia?	❑ NO	❑ YES
limited oral opening?	❑ NO	❑ YES
lip incompetency?	❑ NO	❑ YES
an anterior open bite?	❑ NO	❑ YES
a narrow maxillary arch with vaulted palate?	❑ NO	❑ YES
a posterior crossbite?	❑ NO	❑ YES
macroglossia?	❑ NO	❑ YES

Which Modified Mallampati Classification[1] best describes the patient? ❑ I ❑ II ❑ III ❑ IV



I II III IV

Which tonsillar grade[1] (adapted) best describes the patient? ❑ 0 ❑ 1 ❑ 2 ❑ 3 ❑ 4



0 Surgically removed tonsils

1 Tonsils hidden within tonsil pillars

2 Tonsils extending to the pillars

3 Tonsils are beyond the pillars

4 Tonsils extend to midline

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.