

Pediatric Airway Assessment

This screening form may help identify patients at increased risk for sleep-related breathing disorders (eg, 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: _____ Date of birth: ____/____/____ 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

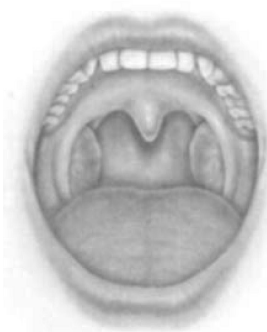
Part IV: Clinical assessment

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

Does the patient have:

- | | | |
|--|-----------------------------|------------------------------|
| limited neck mobility? | <input type="checkbox"/> NO | <input type="checkbox"/> YES |
| micro/retrognathia? | <input type="checkbox"/> NO | <input type="checkbox"/> YES |
| limited oral opening? | <input type="checkbox"/> NO | <input type="checkbox"/> YES |
| lip incompetency? | <input type="checkbox"/> NO | <input type="checkbox"/> YES |
| an anterior open bite? | <input type="checkbox"/> NO | <input type="checkbox"/> YES |
| a narrow maxillary arch with vaulted palate? | <input type="checkbox"/> NO | <input type="checkbox"/> YES |
| a posterior crossbite? | <input type="checkbox"/> NO | <input type="checkbox"/> YES |
| macroglossia? | <input type="checkbox"/> NO | <input type="checkbox"/> YES |

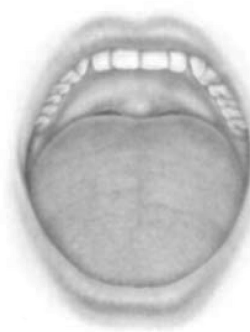
Which Modified Mallampati Classification¹ best describes the patient? ☐ I ☐ II ☐ III ☐ IV



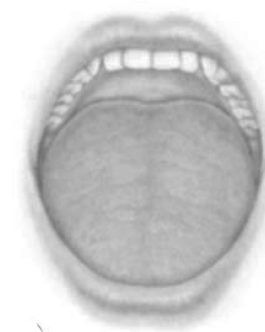
I



II



III



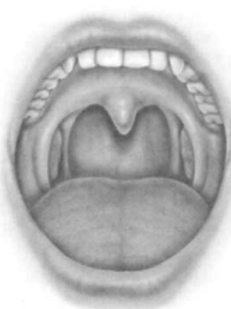
IV

Which tonsillar grade¹ (adapted) best describes the patient? ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4



0

Surgically removed
tonsils



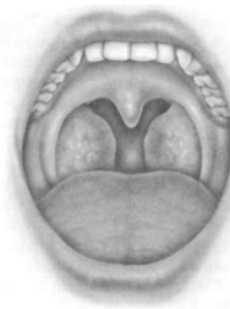
1

Tonsils hidden
within tonsil pillars



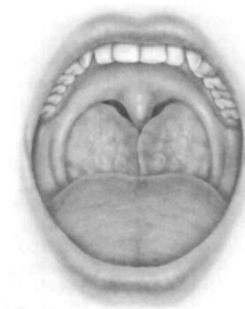
2

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.

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Available at: "<https://onlinelibrary.wiley.com/doi/abs/10.1097/00005537-199912000-00028>".

Laryngoscope is published for the American Laryngological Rhinological and Otological Society by John Wiley and Sons Ltd.