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**

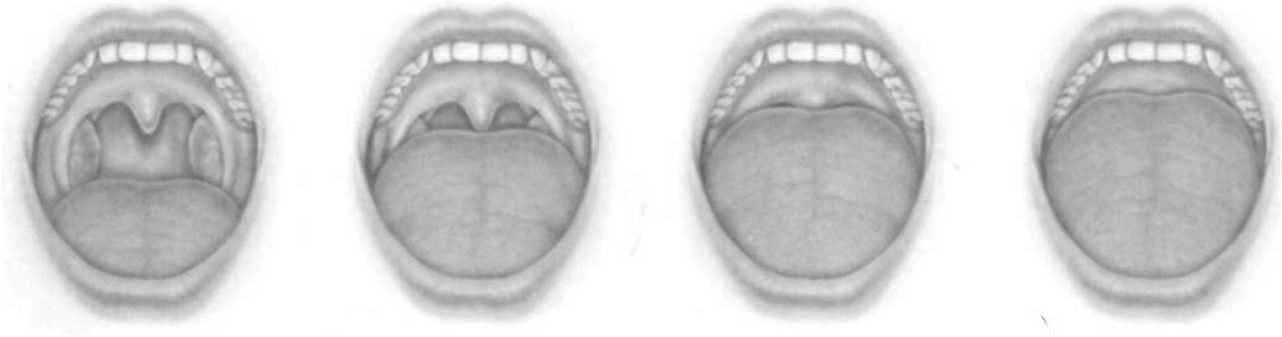
Part IV: Clinical assessment

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

Does the patient have:

limited neck mobility?	❑ 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):1901-1907. DOI: 10.1097/00005537-199912000-00002

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