Lamberg Questionnaire for Pediatric Airway and Sleep
"LQ-PAS"

A Risk Assessment Tool for Pediatric Airway and Sleep

Patient Name/DOB: _____ Date: _____

	Yes	No	Don't Know
While sleeping, does your child…			
have trouble breathing or struggle to breath?			
stop breathing during the night?			
have "heavy" or loud breathing?			
snore regularly?			
snore loudly?			
snore more than half the time?			
appear to be a restless sleeper?			
child kick during sleep?			
have nightmares?			
scream in their sleep?			
grind their teeth during sleep?			
sleepwalk?			
occasionally wet the bed?			
Upon awakening, does your child…			
have a dry mouth in the morning?			
tend to breathe through the mouth during the day?			
wake up feeling un-refreshed in the morning?			
have a problem with sleepiness during the day?			
have trouble getting going in the morning?			
wake up with headaches in the morning?			
We have noticed that our child…			
does not seem to listen when spoken to directly			
has difficulty organizing tasks			
is easily distracted by extraneous stimuli			
fidgets with hands or feet or squirms in seat			
interrupts or intrudes on others (e.g. butts into conversations or games)			
has a teacher or other supervisor comment that your child appears sleepy during the day			
has been diagnosed with ADD or ADHD			
Additionally…			
did your child stop growing at a normal rate at any time since birth?			
is your child overweight?			
does your child's teeth seem crooked or misaligned?			
does your child have allergies?			
does your child have frequent colds?			
does your child have difficulty with pronunciation?			

"ARFs" (Airway Red Flags)

For Physicians Use Only

(Check all that apply)

Signs		Symptoms
___Lips apart at rest (open mouth posture)	___Speech problems	___Difficulties breastfeeding
___Mouth breathing	___Poor eating and swallowing	___Dysphagia
___Lip Incompetence	___Parafunctional habits	___Snoring
___Lip strain when lips together	___Lower jaw set further back than upper jaw (Underbite)	___Tooth grinding
___Swollen adenoids and tonsils	___Eye shiners (dark circles under the eyes)	___Coughs, Colds, and Chest infections
___Forward Tongue Resting Posture	___Bags under eyes	___Chronic allergies
___Tethered Oral Tissues	___Scalloped tongue	___Nasal Congestion
___Restricted Lingual Frenulim	___Arrested growth	___Snoring and fatigue
___High Narrow Palate	___Poor Facial Symmetry	___Asthma symptoms
___Crusty and dry lips and or mouth	___Narrow Posterior Airway Space (on ceph)	___Cognitive communication deficits
___Narrow smile	___Nasal Resistance (CBCT)	___Poor academic performance
___Long Face Height	___Vertical Position of the Hyoid (should be C4, higher or lower not good) Ceph or CBCT	___Language delays
___Flattened Cheeks	___Other _____	___Frequent headaches
___Maxilla retruded	_____	___Frequent nightmares
___Weak Chin (lower jaw retruded)	_____	___Bed Wetting
___Crowded/Crooked teeth		___Child behavioral disorders
___Crossbite and open bite malocclusions		___Aggressive behavior
___Excessively worn teeth		___Irritability
___Gummy Smile		___Possible dx of ADD or ADHD
		___Restless Sleep

Pediatric Airway and Sleep Referral

Date: _____

Patient Name/DOB:_____ Physician: _____

Address:_____ Physician Phone: _____

Phone:_____ Physician Fax: _____

Specialty Evaluation Requested by: ENT, Allergist, Oral Surgeon, Orthodontist, Myofunctional Therapist, Speech/Language Therapist, Neurologist, Dietician, Pediatric Dentist, General Dentist, Psychologist, Sleep Specialist including (Initial consultation, Polysomnogram as necessary, and follow-up)

____ Overnight Attended Sleep Study/Polysomnogram

Reason for referral: _____

_____

Medical History and Pertinent Physical Exam Findings: _____

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