

**SLUMBR2 Sleep Questionnaire**

Study ID: |\_|\_|\_|\_|\_|\_|\_|\_|

Date of completion |\_|\_| / |\_|\_| / 20|\_|\_|

Below are some questions we would like to ask you about your baby's sleeping habits. This questionnaire is divided into two parts, general questions and more specific questions. Please tick the response that best describes your baby. It should take about 10 minutes to fill in.

**General questions**

**1. Have you been given information about what position to place your baby in whilst asleep?**

Yes

No

**2. If yes to question 1, what advice were you given about the best position to put your baby to sleep?**  Not applicable

On their back

On their side

On their front

Other, please describe:

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**3. Who gave you this information?**

Nurse

Doctor

Someone who is not a health care professional, e.g., family friend

Other (specify):

**4. How was that information given to you (you can choose more than one answer)?**

Verbally

Pamphlet / leaflet

Email

Facebook

Online forum

**5. If written information was given, was this about?**  Not applicable

Sleeping position for babies in general

Sleeping position in babies with cleft palate

**6. If verbal information was given, was this about?**  Not applicable

Sleeping position for babies in general

Sleeping position in babies with cleft palate

## SLUMBRS2 Sleep Questionnaire

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7. In general, do you think your baby has good quality sleep?

Yes

No

8. Is your baby fed

Breast milk

Formula milk

Combined breast milk /  
formula feeding

9. Does your baby have medicine for gastric / stomach / acid reflux? (e.g. Gaviscon, Ranitidine, Omeprazole, Domperidone)

Yes

No

If yes, please specify: \_\_\_\_\_

10. Has your baby had any difficulty in gaining weight?

Yes

No

a) If yes, what advice was given to you about your baby's weight and who gave you the advice?

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b) What action (if any) did you take?

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11. Is your baby receiving any nutritional supplements?

Yes

No

If yes, please specify: \_\_\_\_\_

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## Specific Questions

For each of the following questions please tick the most appropriate answer to describe your baby's sleep (either during the daytime or at night).

## 12. Does your baby have difficulty breathing when they are asleep?

- |                          |   |  |  |                                  |                          |
|--------------------------|---|--|--|----------------------------------|--------------------------|
| <input type="checkbox"/> | <input type="checkbox"/>                        | <input type="checkbox"/>                     | <input type="checkbox"/>               | <input type="checkbox"/>         | <input type="checkbox"/> |
| Every day                | Frequently<br>(more than 3<br>days per<br>week) | Sometimes<br>(3 days or<br>less per<br>week) | Occasionally<br>(every 1 – 2<br>weeks) | Only when<br>they have a<br>cold | Never                    |

## 13. Does your baby stop breathing for periods or have pauses in their breathing during sleep?

- |                          |   |  |  |                                  |                          |
|--------------------------|---|--|--|----------------------------------|--------------------------|
| <input type="checkbox"/> | <input type="checkbox"/>                        | <input type="checkbox"/>                     | <input type="checkbox"/>               | <input type="checkbox"/>         | <input type="checkbox"/> |
| Every day                | Frequently<br>(more than 3<br>days per<br>week) | Sometimes<br>(3 days or<br>less per<br>week) | Occasionally<br>(every 1 – 2<br>weeks) | Only when<br>they have a<br>cold | Never                    |

## 14. Does your baby snore / make a noise when they are asleep?

- |                          |   |  |  |                                  |                          |
|--------------------------|---|--|--|----------------------------------|--------------------------|
| <input type="checkbox"/> | <input type="checkbox"/>                        | <input type="checkbox"/>                     | <input type="checkbox"/>               | <input type="checkbox"/>         | <input type="checkbox"/> |
| Every day                | Frequently<br>(more than 3<br>days per<br>week) | Sometimes<br>(3 days or<br>less per<br>week) | Occasionally<br>(every 1 – 2<br>weeks) | Only when<br>they have a<br>cold | Never                    |

## 15. Does your baby make snoring noises while they are awake?

- |                          |   |  |  |                                  |                          |
|--------------------------|---|--|--|----------------------------------|--------------------------|
| <input type="checkbox"/> | <input type="checkbox"/>                        | <input type="checkbox"/>                     | <input type="checkbox"/>               | <input type="checkbox"/>         | <input type="checkbox"/> |
| Every day                | Frequently<br>(more than 3<br>days per<br>week) | Sometimes<br>(3 days or<br>less per<br>week) | Occasionally<br>(every 1 – 2<br>weeks) | Only when<br>they have a<br>cold | Never                    |

## 16. How would you describe your baby's sleep?

- |                          |                          |                          |                          |
|--------------------------|--------------------------|--------------------------|--------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Poor / restless          | Sometimes restless       | Mostly peaceful          | Peaceful                 |

17. If you described your baby's sleep as being poor / restless or sometimes restless, how often is this?  Not applicable

- |                          |   |  |  |                                  |                          |
|--------------------------|---|--|--|----------------------------------|--------------------------|
| <input type="checkbox"/> | <input type="checkbox"/>                        | <input type="checkbox"/>                     | <input type="checkbox"/>               | <input type="checkbox"/>         | <input type="checkbox"/> |
| Every day                | Frequently<br>(more than 3<br>days per<br>week) | Sometimes<br>(3 days or<br>less per<br>week) | Occasionally<br>(every 1 – 2<br>weeks) | Only when<br>they have a<br>cold | Never                    |

