TMJ/SLEEP APNEA THERAPY AND RESEARCH CENTER

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SNORING/SLEEP APNEA FORM

SELF-REPORT DATA (completed by patient):

Date: _____

Name: _____

Address:_____

Age: _____

Referring Doctor: _____

Medical Insurer _____ Dental Insurer: _____

1) Please circle all of the following symptoms you experience:

Apnea(stopping breathing at night) Snoring Insomnia Fatigue during the daytime

2) If you snore, how would you describe it? (circle all that apply)

loud frequent not only when laying on back sleep partners are affected

3) Have you ever been tested for Sleep Apnea: yes no

If yes:

- When were you tested? _____
- What was the severity of the Sleep Apnea: mild moderate severe
- If you know, please list the following values: AHI _____ RDI _____
- What other Sleep Apnea therapies have you tried?
  CPAP Oral Appliances Surgeries Other _____

4) Do you have trouble going to sleep? yes no

If yes, how long does it take you to get to sleep? _____

If you know, please explain why you have this problem: _____

_____

5) Do you sleep through the night without wakening <u>for any reason</u> (including urination)? yes no

If no, how often does this happen? nightly weekly monthly less often

On average, how many times do you awaken per night? _____

If you know, why do you think you do not sleep through the night? _____

_____

6) Do you have good sleep hygiene practices?

- go to bed at same time nightly (most of the time)? yes no

- keep the bedroom dark and cool? yes no

- avoid stimulating influences while in bed (t.v., books, pets, children etc.)? yes no

- avoid drinking alcohol and eating close to bedtime? yes no

- avoid taking medications at bedtime that disrupt sleep (i.e. anti-depressants, caffeine, stimulants, steroids etc.) yes no

7) Do you have pain in your:

- face or jaws yes no
- headaches yes no
- ear pain, tinnitus or stuffiness yes no

8) Do you grind your teeth during sleep? yes no

9) Are your jaws or teeth stiff or sore in the mornings upon wakening? yes no

10) Do your jaws make noise when moving your jaws? yes no

If yes, how do you describe the noise: clicking/popping grinding/sandpaper

11) Do your jaws get stuck open? yes no

Do your jaws get stuck closed? yes no

12) Can you open your mouth as wide as normal? yes no