DENTAL MEDICINE PROVIDERS

TREATMENT OF TMJ AND SLEEP DISORDERS

SLEEP OBSERVER SCALE

Date: ____________________

Patient Name: ____

Observer Name: ____

The following questions relate to the behavior that you have observed in this patient while he/she is asleep. Use the following scale to choose the most appropriate number for each situation.

0 Never
1 Infrequently (one night per week)
2 Frequently (two to three nights per week)
3 Most of the time (four or more nights per week)

	Before Appliance	**After Appliance**	**Notes**
Loud, obstructive or irritating snoring			
Choking or gasping for air			
Pauses in breathing			
Twitching / kicking of arms or legs			
Snoring requiring separate bedrooms			
Falling asleep inappropriately (ie. Driving or in meetings)			
Total Score:			

Note: A score of five or greater indicates symptoms affecting the health, safety or quality of life of the observed person.

problem, please take your time and answer each question as completely and honestly as possible. Please sign each page.

Patient Information

TODAY'S DATE: ________________

☐ MR. ☐ MS ☐ MISS NAME: ______________________________________
☐ MRS. ☐ DR. FIRST MIDDLE INITIAL LAST

AGE: ____________________ BIRTH DATE ____________________ ☐ Male ☐ Female

ADDRESS: ______________________________________

CITY/STATE/ZIP: ______________________________________

HOW LONG AT CURRENT ADDRESS? _________ (IF LESS THAN THREE YEARS, PLEASE GIVE PREVIOUS ADDRESS)

PREVIOUS ADDRESS: ______________________________________

EMPLOYED BY: ______________________________________

ADDRESS: ______________________________________

SS#: ________________ HOME PHONE: ____________________ WORK PHONE: ________________

CELL PHONE: ____________________ EMAIL: ______________________________

RESPONSIBLE PARTY: ______________________________________

FAMILY PHYSICIAN: ______________________________________

ADDRESS: ______________________________________

FAMILY DENTIST: ______________________________________

ADDRESS: ______________________________________

Please list other health care practitioners seen in the last 9 months: ______________________________

____

INSURANCE

MEMBER NUMBER ______________________________

GROUP NUMBER ______________________________

PLAN NUMBER ______________________________

NAME OF PRIMARY CARE PHYSICIAN ______________________________

HEIGHT: _______ feet _______ inches

WEIGHT: _______ pounds

REFERRED BY: ______________________________________

WHAT ARE THE CHIEF COMPLAINTS FOR WHICH YOU ARE SEEKING TREATMENT?

Please number the complaints with #1 being the most important.

- ____ Frequent heavy snoring
  - ____ which affects the sleep of others
- ____ Significant daytime drowsiness
- ____ I have been told that "I stop breathing" when sleeping.
- ____ Difficulty falling asleep
- ____ Gasping when waking up
- ____ Nighttime choking spells
- ____ Feeling unrefreshed in the morning
- ____ Morning hoarseness
- ____ Morning headaches
- ____ Swelling in ankles or feet
- ____ Nocturnal teeth grinding
- ____ Jaw pain
- ____ Facial pain
- ____ Jaw clicking

her: ______________________________ ______________________________

How likely are you to doze off or fall asleep in the following situations?

√ Check one in each row:	0 No chance of dozing	1 Slight chance of dozing	2 Moderate chance of dozing	3 High chance of dozing
Sitting and reading	☐	☐	☐	☐
Watching TV	☐	☐	☐	☐
Sitting inactive in a public place (e.g. a theater or a meeting)	☐	☐	☐	☐
As a passenger in a car for an hour without a break	☐	☐	☐	☐
Lying down to rest in the afternoon when circumstances permit	☐	☐	☐	☐
Sitting and talking to someone	☐	☐	☐	☐
Sitting quietly after a lunch without alcohol	☐	☐	☐	☐
In a car, while stopped for a few minutes in traffic	☐	☐	☐	☐

Total Score: ____________

(Add columns 0-3)

Have you ever had an evaluation at a Sleep Center? ☐ Yes ☐ No

If Yes:

Sleep Center Name and Location ______________________________
____

Sleep Study Date ____________

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The evalution confirmed a diagnosis of: ☐ *mild* ☐ *moderate* ☐ *severe* obstructive sleep apnea

The evaluation showed an RDI of ______ and an AHI of ______

CPAP Intolerance (Continuous Positive Airway Pressure device)

If you have attempted treatment with a CPAP device, but could not tolerate it please fill in this section:

I could not tolerate the CPAP device due to:

- ☐ mask leaks
- ☐ I was unable to get the mask to fit properly
- ☐ discomfort caused by the straps and headgear
- ☐ disturbed or interrupted sleep caused by the presence of the device
- ☐ noise from the device disturbing my sleep and/or bed partner's sleep
- ☐ CPAP restricted movements during sleep
- ☐ CPAP does not seem to be effective
- ☐ pressure on the upper lip causing tooth related problems
- ☐ a latex allergy
- ☐ claustrophobic associations
- ☐ an unconscious need to remove the CPAP apparatus at night

Other: ______________________ ______________________

Other Therapy Attempts

What other therapies have you had for breathing disorders?
(weight-loss attempts, smoking cessation for at least one month, surgeries, etc.)

____
____
____

☐ N☐ Antibiotics
☐ N☐ Aspirin
☐ N☐ Barbiturates
☐ N☐ Codeine
☐ N☐ Iodine
☐ N☐ Latex
☐ N☐ Local anesthetics

Y☐ N☐ Metals
Y☐ N☐ Penicillin
Y☐ N☐ Plastic
Y☐ N☐ Sedatives
Y☐ N☐ Sleeping pills
Y☐ N☐ Sulfa drugs

Other allergens:
____
____
____
____

ist any medications you are currently taking:

☐ N☐ Antacids
☐ N☐ Antibiotics
☐ N☐ Anticoagulants
☐ N☐ Antidepressants
☐ N☐ Anti-inflammatory drugs (non-steroid)
☐ N☐ Barbiturates
☐ N☐ Blood thinners

Y☐ N☐ Codeine
Y☐ N☐ Cortisone
Y☐ N☐ Diet pills
Y☐ N☐ Heart medication
Y☐ N☐ High blood pressure medication
Y☐ N☐ Insulin
Y☐ N☐ Muscle relaxants
Y☐ N☐ Nerve pills

Y☐ N☐ Pain medication
Y☐ N☐ Sleeping pills
Y☐ N☐ Sulfa drugs
Y☐ N☐ Tranquilizers

Other current medications: ______________
____
____

ledical History

☐ N☐ Anemia
☐ N☐ Arteriosclerosis
☐ N☐ Asthma
☐ N☐ Autoimmune disorders
☐ N☐ Bleeding easily
☐ N☐ Chronic sinus problems
☐ N☐ Chronic fatigue
☐ N☐ Congestive heart failure
☐ N☐ Current pregnancy
☐ N☐ Diabetes
☐ N☐ Difficulty concentrating
☐ N☐ Dizziness
☐ N☐ Emphysema
☐ N☐ Epilepsy
☐ N☐ Fibromyalgia
☐ N☐ Frequent sore throats
☐ N☐ Gastroesophageal Reflux Disease (GERD)
☐ N☐ Hay fever
☐ N☐ Heart disorder
☐ N☐ Heart murmur
☐ N☐ Heart pounding or beating irregularly during the night

Y☐ N☐ Heart pacemaker
Y☐ N☐ Heart valve replacement
Y☐ N☐ Heartburn or a sour taste in the mouth at night
Y☐ N☐ Hepatitis
Y☐ N☐ High blood pressure
Y☐ N☐ Immune system disorder
Y☐ N☐ Injury to
☐ Face ☐ Neck
☐ Head ☐ Mouth ☐ Teeth
Y☐ N☐ Insomnia
Y☐ N☐ Irregular heart beat
Y☐ N☐ Jaw joint surgery
Y☐ N☐ Low blood pressure
Y☐ N☐ Memory loss
Y☐ N☐ Migraines
Y☐ N☐ Morning dry mouth
Y☐ N☐ Muscle spasms or cramps
Y☐ N☐ Needing extra pillows to help breathing at night
Y☐ N☐ Nighttime sweating

Y☐ N☐ Osteoarthritis
Y☐ N☐ Osteoporosis
Y☐ N☐ Poor circulation
Y☐ N☐ Prior orthodontic treatment
Y☐ N☐ Recent excessive weight gain
Y☐ N☐ Rheumatic fever
Y☐ N☐ Shortness of breath
Y☐ N☐ Swollen, stiff or painful joints
Y☐ N☐ Thyroid problems
Y☐ N☐ Tonsillectomy (have had)
Y☐ N☐ Wisdom teeth extraction

Other medical history:
____
____
____
____

1. Have any members of your family (blood kin) had:

Yes ☐	No ☐	Heart disease
Yes ☐	No ☐	High blood pressure
Yes ☐	No ☐	Diabetes

2. Have any immediate family members been diagnosed or treated for a sleep disorder? Yes ☐ No ☐

ocial History

Alcohol consumption: How often do you consume alcohol within 2-3 hours of bedtime?

☐ Never ☐ Once a week ☐ Several days a week ☐ Daily ☐ Occasionally

Sedative consumption: How often do you take sedatives within 2-3 hours of bedtime?

☐ Never ☐ Once a week ☐ Several days a week ☐ Daily ☐ Occasionally

Caffeine consumption: How often do you consume caffeine within 2-3 hours of bedtime?

☐ Never ☐ Once a week ☐ Several days a week ☐ Daily ☐ Occasionally

Do you smoke? ☐ Yes ☐ No If yes, enter the number of packs per day (or other description of quantity):

____

Do you use chewing tobacco? ☐ Yes ☐ No

I authorize the release of a full report of examination findings, diagnosis, treatment programs, etc., to any referring or treating dentist or physician. I additionally authorize the release of any medical information to insurance companies or for legal documentation to process claims. I understand that I am responsible for all fees for treatment regardless of insurance coverage.

Patient Signature ________________________________ Date ____________________