SNORING INITIAL EXAMINATION REPORT

PATIENT _____ **REFERRAL** _____
Chief Complaint _____ **Age** _____
Dentist _____ **Exam Date** _____
Medical Doctor _____
Chiropractor _____

Profile	Straight	Prognathic	Retrognathic
MX	Normal	Prognathic	Retrognathic
MD	Normal	Prognathic	Retrognathic

Classifications
☐ Class I
☐ Class II Div 1
☐ Class II Div 2
☐ Class III
☐ Mutilated
☐ Adequate

Type
☐ Dento-Alveolar
☐ Skeletal
☐ Functional
Overjet _____
Overbite _____

Dentition
☐ Primary
☐ Mixed
☐ Permanent
Crossbites _____
Diastema _____

Arch Length
MX ☐ Crowding ☐ Spacing ☐ Adequate
MD ☐ Crowding ☐ Spacing

HABITS Thumb Finger Lip Tongue Thrust
Mouth Breather Poor Lip Seal
Bruxing Clenching Snoring

TMJ
Clicking On Opening On Closing Right Left Both
Pain On Opening On Closing At Rest Right Left Both
Max. Opening _____ mm. **Rt Lateral** _____ mm. **Lt Lateral** _____ mm.
Deflection On Opening On Closing Right Left **Protrusive** _____mm.
Deviation On Opening On Closing Right Left

Has the patient ever had any previous orthodontic or TMJ treatment? Y N

Has the patient ever had a sleep study? Y N
If 'Yes', details _____
_____

Has the patient been diagnosed with sleep apnea? Y N
If 'Yes', Mild _____ **Moderate** _____ **Severe** _____

Has the patient ever been prescribed a CPAP machine? Y N

Does the patient presently wear CPAP? Y N

CASE STATUS
☐ Arrangements have been made to assemble the necessary diagnostic records.
☐ Patient will contact our office if they wish to proceed with treatment.
☐ Patient has decided not to proceed with treatment.

COMMENTS
_____
_____

SCREENING QUESTIONNAIRE
SNORING AND SLEEP APNEA

NAME _____ **DATE** _____

AGE _____ **MALE** **FEMALE** **WEIGHT** _____ **HEIGHT** _____

1. What time do you go to bed? _____ What time do you start your day? _____
2. Do you have difficulty falling asleep at the beginning of the night? Yes No
   If yes, on average, how long does it take to fall asleep? _____
3. Do you have difficulty staying asleep throughout the night? Yes No
   If yes, how many times do you wake up during the night? _____
   How long does it take to fall back to sleep? _____
4. Do you experience an unsettled, restless sensation in your legs while sleeping? Yes No
   If yes, how frequently? Occasionally 50% Every night
5. Have you been told that you make kicking and twitching movements while sleeping? Yes No
6. Do you snore at night? Yes No
   If yes, how would you rate the severity? Mild Moderate Severe
7. Have you been told that you have pauses in your breathing while asleep? Yes No
8. Does your bed partner frequently sleep in another room because of how you sleep? Yes No
9. Do you frequently wake up with:
   A dry mouth? Headaches? Excessive sweating? Choking or gasping?
   Nasal congestion? Chest pain? Heart burn? Drooling on pillow?
10. Are you sleepy during the day? Yes No
11. Do you take naps often? For how long? _____ Yes No
12. How many caffeinated beverages do you consume each day? _____
13. Do you occasionally awaken feeling paralyzed? Yes No
14. Do you experience sudden loss of strength in your legs or arms during the day? Yes No
    If yes, are these brought on by a sudden frightening event or laughter? Yes No

15. How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired?
    0 = Never Doze 1 = Slight Chance 2 = Moderate Chance 3 = High Chance

Situation	Chance of Dozing			
Sitting and reading	0	1	2	3
Watching T.V.	0	1	2	3
Sitting, inactive in a public place (theatre)	0	1	2	3
As a passenger in a car for an hour without a break	0	1	2	3
Lying down to rest in the afternoon	0	1	2	3
Sitting and talking to someone	0	1	2	3
Sitting quietly after lunch without alcohol	0	1	2	3
In a car, while stopped for a few minutes in traffic	0	1	2	3

Please list your medications

Please list your medical conditions, past and present

_____

_____