Version: SLPQV4

Sleep Appliance Use

OFFICE USE
Patient ID:

NAME: ____________________

CURRENT DATE: ___/___/______

DATE OF BIRTH: __/__/_____

☐ MALE

☐ FEMALE

Appliance Use

What is your Snore Lab score range?
- ☐ No
- ☐ Yes
- ☐ I do not use the App
- ☐ ________

☐ Average hours you sleep each night

How long does it take for you to fall asleep in minutes?
- ☐ 60mins
- ☐ 1 minute
- ☐ 10 minutes
- ☐ 20 minutes
- ☐ 30 minutes
- ☐ ________

Snoring
- ☐ Yes
- ☐ No
- ☐ Reduced
- ☐ Not sure
- ☐ N/A
- ☐ ________

Percentage of the hours you sleep you wear the appliance
- ☐ 100%
- ☐ 75%
- ☐ 50%
- ☐ 25%
- ☐ 0%
- ☐ ________

Excessive daytime sleepiness
- ☐ Yes
- ☐ No
- ☐ Sometimes
- ☐ Same
- ☐ Reduced
- ☐ ________

Tooth tenderness
- ☐ Yes
- ☐ No
- ☐ Occasionally
- ☐ for about 5 mins
- ☐ for about 10 mins
- ☐ 1 hour
- ☐ ________

Do you sleep easily with the appliance? ☐ Yes ☐ No

All night ☐ Yes ☐ No

Every night ☐ Yes ☐ No

Does it fit well? ☐ Yes ☐ No

Do you notice that you dream more? ☐ Yes ☐ No

Temporomandibular joint tenderness
- ☐ Yes
- ☐ No
- ☐ Occasionally
- ☐ Unsure
- ☐ ________

Patient Signature: ____________________

Date: ________

Appliance Use

Changes in tooth contact
- ☐ Yes
- ☐ No
- ☐ No change
- ☐ Unsure
- ☐ Minor
- ☐ For less than an hour
- ☐ ______

AM positioner utilization
- ☐ Yes
- ☐ No
- ☐ Sometimes
- ☐ ______

Patient Signature

Because of HIPAA Federal regulations protecting your privacy, we wish to inform you that we will release no information about you without your consent. By agreeing to this consent, you permit the release of any information to or from your dental practitioner as required including a full report of examination findings, diagnosis and treatment program to any referring or treating dentist or physician. You understand that you are financially responsible for all charges whether or not paid by insurance. Your dental practitioner may use your health care information and may disclose such information to your Insurance Company(ies) and their agents for the purpose of obtaining payment for service and determining insurance benefits or the benefits payable for related services.

Patient Signature: ______ Date: ______

I certify that the medical history information is complete and accurate.

Patient Signature: ______ Date: ______

SLEEP DISORDER ASSESSMENT Steven Wilk, DDS

Date__________________

Name: Last______________________ First _______________________ MI ________

Date of Birth: _________________ _____ Male _____ Female

Height ____ ft _____ in **Weight** __________ lbs.

How likely are you to doze off or fall asleep in the following situations? This refers to recent times. Even if you have not done some of these things, try to imagine how these situations would affect you. Use the following 0-3 scale to mark the most appropriate box for each situation:
0 = would never doze; 1 = slight chance of dozing; 2 = moderate chance of dozing; 3 = high chance of dozing

Situation				
Sitting and reading	0	1	2	3
Watching TV	0	1	2	3
Sitting, inactive in public place (theater, church, etc.)	0	1	2	3
Passenger in a car for 1 hour	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	0	1	2	3
In a car, while stopped in traffic for a few minutes	0	1	2	3