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Patient Questionnaire for Sleep Disturbance, Obstructive Apnea, and Snoring: Night-time Intra-oral Appliances

Name: _____ Age: _____ Sex: M F Hr _____ Wt _____

Phone: Home _____ Work _____

Please answer the following questions by indicating frequency according to these guidelines:

- Daily - Every or almost every night or day
- Often - At least once or twice per week
- Infrequently - Less than once a week
- Never

During your usual sleep, have you noticed or have you been told that you do the following:
 (check one answer in each category)

| | Daily | Often | Infreq | Never |
|---|-------|-------|--------|-------|
| A. Snore loudly | _____ | _____ | _____ | _____ |
| B. Choke, struggle for breath or stop breathing | _____ | _____ | _____ | _____ |
| C. Awaken repeatedly because of a breathing problem | _____ | _____ | _____ | _____ |
| D. Toss and turn frequently | _____ | _____ | _____ | _____ |
| E. Kick or jerk legs repeatedly | _____ | _____ | _____ | _____ |

When you wake up after your usual sleep, how often do you experience the following:

| | Daily | Often | Infreq | Never |
|---------------------------|-------|-------|--------|-------|
| A. Headache | _____ | _____ | _____ | _____ |
| B. Dry mouth | _____ | _____ | _____ | _____ |
| C. Feel tired or unrested | _____ | _____ | _____ | _____ |

During the time when you are usually awake (Daytime and evening), how often do you become irresistibly sleepy or do you fall asleep in the following situations:

| | Daily | Often | Infreq | Never |
|-----------------------------------|-------|-------|--------|-------|
| A. After a meal | _____ | _____ | _____ | _____ |
| B. Reading or watching t.v. | _____ | _____ | _____ | _____ |
| C. At church or school | _____ | _____ | _____ | _____ |
| D. At work | _____ | _____ | _____ | _____ |
| E. While a passenger in a vehicle | _____ | _____ | _____ | _____ |
| F. While driving a vehicle | _____ | _____ | _____ | _____ |

Do you have trouble breathing through your nose:

| | Daily | Often | Infreq | Never |
|----------------------|-------|-------|--------|-------|
| A. Daytime | _____ | _____ | _____ | _____ |
| B. Nighttime, in bed | _____ | _____ | _____ | _____ |

Do you consume any alcoholic beverages or take sedatives:

| | Daily | Often | Infreq | Never |
|----------------------|-------|-------|--------|-------|
| A. Daytime | _____ | _____ | _____ | _____ |
| B. Nighttime, in bed | _____ | _____ | _____ | _____ |

Have you had or used any of the following:

| | | | | | |
|-------------|---------|----------------|---------|-----------------|---------|
| Nose broken | Y__ N__ | Nose surgery | Y__ N__ | Tonsillectomy | Y__ N__ |
| Hay fever | Y__ N__ | Sinus problems | Y__ N__ | Antihistamines | Y__ N__ |
| Cigarettes | Y__ N__ | Nasal sprays | Y__ N__ | Prev. treatment | Y__ N__ |

