TMJ FORM & SLEEP APNEA

Please answer the following questions as completely and accurately as you can. Also, please be as detailed as possible providing additional information you think is important. If you have any questions about this form, or your upcoming appointment, contact our office for assistance. Please circle YES and No. If YES, please explain on the line provided.

TMJ HISTORY

1. YES NO Do you ever have a burning or painful sensation in your mouth? _____
2. YES NO Do you get popping, clicking, or grinding noises when you open or close? _____
3. YES NO Do you ever awaken with an awareness of your teeth or jaws? _____
4. YES NO Are you aware of clenching during the daytime? How often? _____
5. YES NO Have you ever been told you grind your teeth during sleep? _____
6. YES NO Do you have trouble opening your mouth widely? _____
7. YES NO Does your jaw ever lock open or closed? How often? _____
8. YES NO Do you feel your bite is different, unstable or uncomfortable? _____
9. YES NO If you sought treatment for a TMJ problem, did it help? _____
10. YES NO Do you or have you had any pain in any of the following areas? (circle)
    Jaw Ear Face Neck Teeth Head Other _____
11. YES NO Do your jaw problems affect your ability to chew? _____
12. YES NO Has your diet changed due to your jaw problems? Describe_____
13. YES NO Do your joint noises affect others while eating? _____

SLEEP, SNORING AND APENA HISTORY

14. YES NO Do you become easily fatigued? At what time of day? _____
15. YES NO Do you have problems with insomnia? _____
16. YES NO Do you sleep well? How long? _____
17. YES NO Do you dream? How often? _____
18. YES NO Do you have trouble falling asleep or staying asleep? Which_____
19. YES NO Do you snore or have you been told you do? _____
20. YES NO Do you wake up with a headache? _____
21. YES NO Have you had chronic sleepiness, fatigue or weariness that you can't explain? _____
22. YES NO Do you often fall asleep reading or watching television? _____
23. YES NO Have you fallen asleep during the day against your will? _____
24. YES NO Have you had to pull off the road while driving due to sleepiness? _____
25. YES NO Have you been more irritable and short tempered?_____
26. YES NO Have you felt that your memory and/or intellect is impaired? _____
27. YES NO Have you been told that you stop breathing while asleep? _____
28. About how many times per night do you wake up? _____
29. What time do you normally go to bed?_____ Get up in the morning? _____
30. Of the hours you are in bed, about how many hours are you asleep? _____

(Please complete both side of the form)

31. Would you rate the quality of your sleep as ▢ Good ▢ Fair ▢ Poor?
32. YES NO Do you have difficulty breathing through your nose? _____
33. YES NO Have you been diagnosed or treated for a sleep disorder? When_____
34. YES NO Have any immediate family members been diagnosed or treated for a sleep disorder?
35. YES NO Have you ever had an evaluation at a sleep center?
    Sleep Center Name:_____
    Location: _____
    Sleep Study Date: _____
36. What professional advice or treatment have you received about your snoring or sleep apnea?
    _____
    _____
37. YES NO If you sought treatment for a sleep disorder, did it help?_____
    _____

Have you ever been diagnosed with the following?

38. YES NO **Obstructive Sleep Apnea**
39. YES NO **Loud Snoring**
40. YES NO **High Blood pressure**
41. YES NO **Heart disease**
42. YES NO **Stroke**
43. YES NO **Diabetes**
44. YES NO **Thyroid**
45. YES NO **Insomnia**
46. YES NO **Depression**
47. YES NO **COPD**
48. YES NO **Morning Headache**
49. YES NO **Restless Leg Syndrome**
50. YES NO **Night time Urination**

EPWORTH SLEEPINESS QUESTIONNAIRE

Use the following scale to choose and circle the most appropriate number for your situation

0 = Never Doze 1 = Slight Chance 2 = Moderate Chance 3 = High Chance

Sitting and reading	**0**	**1**	**2**	**3**
Sitting quietly in a public place	**0**	**1**	**2**	**3**
Watching TV	**0**	**1**	**2**	**3**
Sitting quietly after lunch w/o alcohol	**0**	**1**	**2**	**3**
As a passenger in a car not stopping to stretch	**0**	**1**	**2**	**3**
In a car while stopped in traffic for a few minutes	**0**	**1**	**2**	**3**
Laying down to rest in the afternoon	**0**	**1**	**2**	**3**
Sitting and talking to someone	**0**	**1**	**2**	**3**

_____ **Total Score**

I certify that the above information is correct to the best of my knowledge

PATIENT/GUARDIAN SIGNATURE _____DATE_____