Email Submit

Oral Appliance Treatment Update Questionnaire

Last Name _____ First Name: _____

Date of Birth: _____ Date: _____

Since your last visit:

1. What percentage of nights have you used the oral appliance?

100%	90%	80%	70%	60%	50%	40%	30%	<20%
☐	☐	☐	☐	☐	☐	☐	☐	☐

2. How satisfied are you with the oral appliance for the treatment of your sleep apnea problem?

◯ Very ◯ Moderately ◯ Mildly ◯ Unsatisfied

3. How difficult has it been for you to use the oral appliance?

◯ Not Difficult ◯ Very Little ◯ Some Problems ◯ Difficult

4. Have you had an illness that affected your ability to wear the appliance?

◯ Yes ◯ No

5. Does your bite feel different after removing the appliance?

◯ Yes ◯ No

For the following questions, please respond "Never", "Rarely", "Sometimes" or "Often." When applicable, rate severity of side effect as "Mild", "Moderate" or "Severe."

Select	N/A	Have you snored or been told that you do?
Select	N/A	Have you had morning fatigue, fogginess or woken up feeling un-refreshed?
Select	N/A	Have you been told you stop breathing?
Select	N/A	Have you fallen asleep during the day?
Select	N/A	Have you had tooth discomfort?
Select	N/A	Have you had jaw discomfort?
Select	N/A	Have you had gum discomfort?
Select	N/A	Have you had a sense of suffocation?
Select	N/A	Ear pain?
Select	N/A	Excessive salivation?

If you have discontinued using the appliance, please state why:

What do you dislike about your device?

What one thing would you change about your device if you could?

Oral Appliance Treatment Update Questionnaire

Cahill DENTAL CARE
Dental Solutions for Restful Sleep

Last Name _____ First Name: _____

Date of Birth: _____ Date: _____

Epworth Sleepiness Scale:

How likely are you to doze off or fall asleep in the following circumstances, in contrast to feeling just tired? This refers to your usual way of life in recent times. Even if you have not done some of these things recently, try to work out how they would have affected you. Using the scale below, circle the most appropriate number for each situation and add up your total score.

SCALE:

0 - Would Never Fall Asleep
1 - Slight Chance of Dozing
2 - Moderate Chance of Dozing
3 - High Chance of Dozing

Situation:	Scale:
Sitting and reading	Select
Watching television	Select
Sitting inactive in a public place (i.e. a theater)	Select
A passenger in a car for an hour without a break	Select
Lying down to rest in the afternoon when possible	Select
Sitting and talking to someone	Select
Sitting quietly after a lunch without alcohol	Select
In a car while stopped for a few minutes in traffic	Select
Total:	0
Quality of sleep: Poor? Average? Good?	Select

Additional comments: (i.e. Alcohol consumption, sleep medication, indicate CPAP pressure for follow up study. etc.)

None

Signed: _____ Date: _____