BITTNER
DENTAL CLINIC
mouthwash365.com

Sleep Survey

Dr. Bittner requests that you complete this "Sleep Disorder Assessment Form."

Please complete the following survey. Your answers will help us determine if an underlying sleep limitation may be affecting your overall health.

ANSWER KEY TO THE QUESTIONS BELOW

0 = No Chance of Dozing **1 = Slight** Chance of Dozing **2 = Moderate** Chance of Dozing **3 = High** Chance of Dozing

Sitting and Reading	0 ☐	1 ☐	2 ☐	3 ☐
Sitting inactive in public place (theatre)	0 ☐	1 ☐	2 ☐	3 ☐
As a car passenger for an hour without a break	0 ☐	1 ☐	2 ☐	3 ☐
In a car while stopped at a traffic light	0 ☐	1 ☐	2 ☐	3 ☐
Sitting quietly after lunch without alcohol	0 ☐	1 ☐	2 ☐	3 ☐
Sitting and talking to someone	0 ☐	1 ☐	2 ☐	3 ☐
Laying down in the afternoon to rest	0 ☐	1 ☐	2 ☐	3 ☐
Watching TV	0 ☐	1 ☐	2 ☐	3 ☐

THORNTON SNORING SCALE

0 = Never **1 = 1 Night a Week** **2 = 2-3 nights a week** **3 = 4+ nights a week**

My snoring affects my relationship	0 ☐	1 ☐	2 ☐	3 ☐
My snoring is loud	0 ☐	1 ☐	2 ☐	3 ☐
My snoring affects people when I am sleeping away from home	0 ☐	1 ☐	2 ☐	3 ☐
My snoring requires us to sleep in separate rooms	0 ☐	1 ☐	2 ☐	3 ☐
My snoring causes my partner to be irritable or tired	0 ☐	1 ☐	2 ☐	3 ☐
Sitting quietly after lunch without alcohol	0 ☐	1 ☐	2 ☐	3 ☐
Sitting and talking to someone	0 ☐	1 ☐	2 ☐	3 ☐
Lying down in the afternoon to rest	0 ☐	1 ☐	2 ☐	3 ☐

Total: _____

PLEASE LIST THE MAIN REASON(S) YOU ARE SEEKING TREATMENT FOR SNORING OR SLEEP APNEA:

_____

_____

_____

CONT.

DO YOU HAVE OTHER COMPLAINTS?

Frequent snoring	Yes ☐ No ☐	Difficulty maintaining sleep	Yes ☐ No ☐
Excessive Daytime Sleepiness (EDS)	Yes ☐ No ☐	Choking while sleeping	Yes ☐ No ☐
Difficulty falling asleep	Yes ☐ No ☐	Feeling unrefreshed in the morning	Yes ☐ No ☐
Waking up gasping/choking	Yes ☐ No ☐	Memory problems	Yes ☐ No ☐
Morning headaches	Yes ☐ No ☐	Impotence	Yes ☐ No ☐
Neck or facial pain	Yes ☐ No ☐		

Nasal problems, difficulty breathing through nose Yes ☐ No ☐

I have been told I stop breathing when I sleep Yes ☐ No ☐

Are you irritable or do you have mood swings Yes ☐ No ☐

Others: _____

_____

SUBJECTIVE SIGNS AND SYMPTOMS

Rate your overall energy level **1 (Low)** ☐ **2** ☐ **3** ☐ **4** ☐ **5 (High)** ☐

Rate your sleep quality **1 (Poor)** ☐ **2** ☐ **3** ☐ **4** ☐ **5 (Good)** ☐

Rate the sound of your snoring **1 (Quiet)** ☐ **2** ☐ **3** ☐ **4** ☐ **5 (Loud)** ☐

Do you have a bed partner? **Yes** ☐ **No** ☐

Do you sleep in the same room? **Yes** ☐ **No** ☐

On average, how many times per night do you wake up? _____

On average, how many hours of sleep do you get per night? _____

How often do you awaken with headaches? **1 (Never)** ☐ **2 (Rarely)** ☐ **3 (Sometimes)** ☐ **4 (Often)** ☐ **5 (Daily)** ☐

Doctor Notes: _____

_____

_____

DENTAL HEALTH SURVEY

When was your last dental check-up/complete exam? _____

When was your last dental cleaning? _____

How often do you have your teeth cleaned per year? _____

When was your last dental treatment? What was done? _____

Dentist name and contact info. _____

CONT.

SLEEP SURVEY CONT. 3

Are you experiencing any oral pain or discomfort now?	**Yes** ☐	**No** ☐
Do you brush your teeth twice a day or more?	**Yes** ☐	**No** ☐
Do you use a fluoride toothpaste?	**Yes** ☐	**No** ☐
Do you rinse with mouthwash every time you brush?	**Yes** ☐	**No** ☐
Do your gums bleed when you brush or floss?	**Yes** ☐	**No** ☐
Does food tend to collect between certain teeth?	**Yes** ☐	**No** ☐
Do any of your teeth feel loose or move?	**Yes** ☐	**No** ☐
Are any of your teeth sensitive to cold, hot, sweet or pressure?	**Yes** ☐	**No** ☐
Are you aware of grinding or clenching your teeth?	**Yes** ☐	**No** ☐
Do you have difficulty chewing?	**Yes** ☐	**No** ☐
Do you ever experience tired jaw muscles?	**Yes** ☐	**No** ☐
Do you have clicking, popping or grating noises in your jaw joint?	**Yes** ☐	**No** ☐
Do you have any pain in or around your jaw joints?	**Yes** ☐	**No** ☐
Do you experience tension headaches or ringing in your ears?	**Yes** ☐	**No** ☐
Are you taking antidepressants or other medications that may affect muscle activity or cause dry mouth?	**Yes** ☐	**No** ☐
Do you experience dry mouth when you wake up or at any other time?	**Yes** ☐	**No** ☐
Do you have any sores or ulcers in or around your mouth?	**Yes** ☐	**No** ☐
Do you have persistent bad breath?	**Yes** ☐	**No** ☐
Do you have any discolored teeth?	**Yes** ☐	**No** ☐
Do you have any missing teeth?	**Yes** ☐	**No** ☐
Do you have any implants or removable partials or dentures?	**Yes** ☐	**No** ☐
Have you had orthodontic treatment?	**Yes** ☐	**No** ☐
Have you ever had a serious injury to your head or mouth?	**Yes** ☐	**No** ☐

How would you rate your smile? **1(One of my best features)** ☐ **2(My smile is nice and healthy)** ☐
3(Could be healthier) ☐ **4(Needs improvement)** ☐ **5(I don't smile often)** ☐

Name - First _____ Last _____

Email _____ Phone ( ) _____

Address _____

City _____ State _____ Zip _____

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