DENZINGER
FAMILY DENTISTRY

Adult Sleep Disorder Evaluation

Patient Name _____ Date _____

Have you had or do you currently have any of the following?

- ☐ Headache pain
- ☐ Ear pain
- ☐ Jaw pain
- ☐ Pain when chewing
- ☐ Facial pain
- ☐ Eye pain
- ☐ Throat pain
- ☐ Neck pain
- ☐ Shoulder pain
- ☐ Back pain
- ☐ Limited ability to open mouth
- ☐ Jaw joint locking
- ☐ Jaw joint noises
- ☐ Ear congestion
- ☐ Sinus congestion
- ☐ Dizziness
- ☐ Tinnitus (ringing in the ears)
- ☐ Muscle twitching
- ☐ Vision problems
- ☐ Kicking or jerking leg repeatedly
- ☐ Swelling in ankles or feet
- ☐ Morning hoarseness
- ☐ Dry mouth upon waking
- ☐ Fatigue
- ☐ Difficulty falling asleep
- ☐ Tossing and turning frequently
- ☐ Repeated awakening
- ☐ Feeling un-refreshed in the morning
- ☐ Significant daytime drowsiness
- ☐ Frequent heavy snoring
- ☐ Affect sleep of others
- ☐ Gasping when waking
- ☐ Told that "I stop breathing" during sleep
- ☐ Night-time choking spells
- ☐ Unable to tolerate C-Pap
- ☐ Tooth grinding
- ☐ Teeth crowding
- ☐ Other _____

Situation *(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.)*	**Chance of Dozing** *0 = Would never doze* *1 = Slight chance of dozing* *2 = Moderate chance of dozing* *3 = High chance of dozing*
Sitting and reading	
Watching TV	
Sitting, inactive, in a public place	
As a passenger in a car for an hour	
Lying down in the afternoon	
Sitting and talking to someone	
Sitting quietly after a lunch without alcohol	
In a car, while stopped for a few minutes in traffic	