

Patient Name: _____ Date of Birth: _____
 Phone (home): _____ (work) _____ (mobile) _____
 Your Doctor's (GP) name: _____
 Your Doctor's (GP) address: _____ Phone: _____
 Referring Specialist Physician's Name: _____ Phone: _____

Medical Conditions

Do you have any condition that your GP is aware of?

Respiratory	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Cardiovascular	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Renal	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Digestive	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Neurological	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Please tick yes or no. **(You may need to ask your bed partner for some of these answers).**

- | | | |
|---|------------------------------|-----------------------------|
| 1. Do you snore or have you been told you snore? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 2. Do you snore only when you are lying on your back? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 3. Do you snore loudly? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 4. Do you snore every night? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 5. Have you been told you stop breathing or gasp during sleep? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 6. Has your partner had to move to another room during the night? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 7. Have you had or been treated for high blood pressure? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 8. Do you doze off unintentionally during the day? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 9. Do you often wake feeling tired? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 10. Do you often wake in the morning with a headache? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 11. Do you have problems concentrating for long periods of time? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 12. Do you feel pain in your jaw joints (area of the ear)? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 13. Do you grind or clench your teeth in your sleep? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 14. Have you ever been diagnosed, or do you suspect you have OSA?* | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 15. Have you ever been seen by a specialist for snoring or OSA?* | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 16. Have you ever had a sleep study?* | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 17. Have you ever been treated for snoring, OSA or a sleep disorder?* | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

* If yes, where and when? _____

Family History

Have any family members had heart disease/high blood pressure/diabetes? Yes No
 Do any family members snore, have OSA or a sleep disorder? Yes No
 Is yes, who? _____

Personal Information

Weight: _____
 Height: _____
 Neck circumference: _____
 Male: greater than 43cm Female: greater than 41cm
 Alcohol consumption (units per week) _____
 Smoking consumption (cigarettes/cigars per week) _____

How likely are you to fall asleep in the following situations?

- 0 = would never doze
- 1 = slight chance of dozing
- 2 = moderate chance of dozing
- 3 = high chance of dozing

Activity

- Sitting and reading
- Watching television
- Sitting, inactive in a public place (theater, meeting)
- As a passenger in a car for an hour with no break
- Lying down to rest in the afternoon, if circumstances permit
- Sitting and talking to someone
- Sitting quietly after lunch without alcohol
- In a car while stopped for a few minutes in traffic

SCORE

TOTAL SCORE:

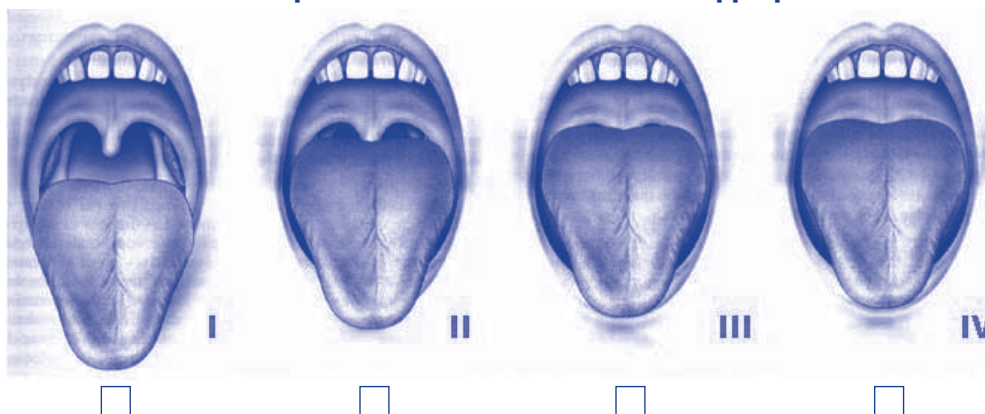
A score of 10 or above indicates you may be having a problem with daytime sleepiness. However, below 10 does not necessarily mean you do not have a problem.

Dentist Use Only

OSA Symptoms (if patient answers yes to one or more, consider referral to a GP)

- | | | |
|---|------------------------------|-----------------------------|
| Choking or gasping during sleep | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Tiredness on waking | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Sore, dry throat on waking | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Morning headache, excessive daytime sleepiness | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Decreased sex drive or impotence | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Gastro-oesophageal reflux | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Nocturia | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Personality changes, which may include irritability | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Decreased job performance | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Anxiety or depression | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Poor concentration / memory | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

Mallampati Classification – Please tick appropriate box below:



Dental Practitioner

1. Dental Exam: Tooth Exam Soft Tissue
 Comments: _____

2. Periodontal Exam: Healthy _____ Gingivitis _____ Periodontitis _____

3. Radiographic: OPG _____ Lateral Skull _____ TMJ _____

4. Findings: Caries: _____ Bone Loss: mild /moderate/severe Lucencies: _____
 Other Abnormalities: _____

Gag reflex:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Mouth breather:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Inflamed or swollen uvula:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Tonsils:	<input type="checkbox"/> Present	<input type="checkbox"/> Absent

Examination for TMD

Masticatory Muscle Palpation

- | | | | |
|----|--|------------------------------|-----------------------------|
| a. | Temporalis soreness | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| b. | Masseter soreness | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| c. | Digastric soreness | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| d. | Medial pterygoid soreness | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| e. | Lateral pterygoid soreness | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| f. | TM Joint | | |
| | Right joint: | | |
| | <input type="checkbox"/> clicking or popping | | |
| | <input type="checkbox"/> soreness on palpation | | |
| | <input type="checkbox"/> other noises _____ | | |
| | Left joint: | | |
| | <input type="checkbox"/> clicking or popping | | |
| | <input type="checkbox"/> soreness on palpation | | |
| | <input type="checkbox"/> other noises _____ | | |

Range of Motion

Opening _____ mm Pain on Opening Yes No
 Lateral deviation: R _____ mm L _____ mm

Lateral Movement

Left lateral movement _____ mm Pain Yes No
 Right lateral movement _____ mm Pain Yes No

Protrusion

Maximum protrusion _____ mm Pain Yes No
 Deviation on protrusion R _____ mm L _____ mm

Is there a Tempero-mandibular Disorder? Yes No Mild/Mod/Severe

MAS suitability Yes No Maybe

