Follow-up Sleep & Breathing Questionnaire

Date: _____

Patients Name: _____

DOB: _____

How many weeks / months have you been in your appliance? _____

How many hours a day are you wearing your appliance? _____ hours a week? _____

How are you cleaning your appliance at home? Soaking, Brushing please explain

_____

Have you noticed any changes after starting appliance therapy?

Changes with feeling tired and unrested?	YES ☐	NO ☐
Changes with snoring?	YES ☐	NO ☐
Changes with hypertension/high blood pressure?	YES ☐	NO ☐
Changes with morning headaches?	YES ☐	NO ☐
Changes with daytime drowsiness or fatigue?	YES ☐	NO ☐
Changes in Nasal Breathing?	YES ☐	NO ☐
Changes with stopping breathing during your sleep?	YES ☐	NO ☐
Changes with waking up choking or gasping?	YES ☐	NO ☐
Changes with teeth grinding while sleeping?	YES ☐	NO ☐
Changes with dry mouth?	YES ☐	NO ☐
Changes with weight?	YES ☐	NO ☐

Are there any noticeable changes in your overall health after starting treatment that you would like to talk about? If yes, please explain in your own words.

_____

*Do you have any other concerns you would like to address? If yes, please explain in your own words on the back side of this questionnaire. Thank you for your time!