TMJ History

23. Do you have chronic headaches? Yes__ No__
24. Do you have chronic neck pain? Yes__ No__
25. Are you aware of your jaw popping, clicking or making noises? Yes__ No__
26. Do you ever have pain or ringing in the ears? Yes__ No__
27. Do your jaw muscles feel tired, stiff or painful? Yes__ No__
28. Are you aware of clinching your teeth during the day? Yes__ No__
29. Have you ever been told you grind your teeth at night? Yes__ No__
30. Do you ever awaken with an awareness of your teeth or jaws? Yes__ No__
31. Do you have trouble opening your mouth widely? Yes__ No__
32. Does your jaw ever lock open or closed? Yes__ No__
33. Do you feel your bite is different, unstable, or uncomfortable? Yes__ No__
34. Have you sought treatment for a TMJ problem? Yes__ No__
35. Does your jaw affect your ability to chew? Yes__ No__

Sleep, Snoring, and Apnea History

36. Do you become easily fatigued? Yes__ No__
    What time of day?_____
37. Do you have problems with insomnia? Yes__ No__
38. Do you sleep well? Yes__ No__
    How long?_____
39. Do you dream? Yes__ No__
    How often?_____
40. Do you have trouble falling asleep or staying asleep? Yes__ No__
    Which one?_____
41. Do you snore or have been told you do? Yes__ No__
42. Do you wake up with a headache? Yes__ No__
43. Have you had chronic sleepiness, fatigue, or weariness that you cannot explain? Yes__ No__
44. Do you often fall asleep watching television or reading? Yes__ No__
45. Have you fallen asleep during the day against your will? Yes__ No__
46. Have you had to pull off the road while driving due to sleepiness? Yes__ No__
47. Have you been more irritable or short-tempered? Yes__ No__
48. Have you felt that your memory and/or intellect is impaired? Yes__ No__
49. Have you been told that you stop breathing while asleep? Yes__ No__
50. About how many times per night do you wake up?_____
51. What time do you normally go to bed?_____Get up in the morning?_____
52. Of the hours in bed, how many are you asleep?_____
53. Would you rate the quality of your sleep ___GOOD ___FAIR___POOR___
54. Do you have difficulty breathing through your nose? Yes__ No__
55. Present body weight_____lbs. Height_____ft._____inches
56. Have you been diagnosed or treated for a sleep disorder? Yes__ No__
    When?_____
57. Have any immediate family members been diagnosed or treated for a sleep disorder? Yes__ No__
58. Have you ever had an evaluation at a sleep center? Yes__ No__
    Sleep Center Name_____
    Location_____
    Sleep Study Date_____
59. If you sought treatment for a sleep disorder, did it help? Yes__ No__