Sleep Apnea Therapy of Southern New England

Patient name: _____ Date of Birth: _____

What is the reason for your visit today?

Reported Usage:

Average number of hours wearing appliance?			
☐Every Night	☐ Most Nights	☐Occasionally	☐Not wearing

Energy Level

☐More rested than last visit	☐ Less rested than last visit	☐About the same

Snoring Level

☐Never snored	☐ Better than last visit	☐Worse than last visit
☐No change	☐ Unknown, sleep alone	

Current Position Subjectively Effective:

☐Yes	☐No	☐Partially

Subjective Improvements:

☐More dreams	☐Decreased nocturia	☐Fewer AM headaches
☐Deeper sleep	☐Less excessive daytime sleepiness	

Fit of Device:

☐Just right	☐ Too tight	☐ Too loose

Side Effects:

☐Jaw/Muscle Pain	☐Tooth Movement	☐Tooth pain	☐ None
☐Bite changes	☐ Bite feels different in AM	☐Headaches	☐ Ear Problems
☐TMJ pain or dysfunction since using the appliance			☐Using AM aligner each AM