Brander Sleep Wellness, LTD
5668 E. State Street, Suite 1100
Rockford, IL 61108
815-977-5281

Patient Name: _____

Today's Date: _____

Sleep Apnea/ TMD Patient Report

Patient's Chief Complaint / Narrative:

Please indicate the chief complaints for which you are seeking treatment. For the symptoms you check, please specify the severity of those symptoms on a scale of 1(slightly bothersome) to 5 (very bothersome).

TMD

☐ Difficulty Swallowing	1 2 3 4 5
☐ Dizziness	1 2 3 4 5
☐ Facial Pain	1 2 3 4 5
☐ Headaches	1 2 3 4 5
☐ Jaw Clicking	1 2 3 4 5
☐ Jaw Locking	1 2 3 4 5
☐ Jaw Pain	1 2 3 4 5
☐ Limited Mouth Opening	1 2 3 4 5
☐ Migraines	1 2 3 4 5
☐ Morning Hoarseness	1 2 3 4 5
☐ Neck Pain	1 2 3 4 5
☐ Nocturnal Teeth Grinding	1 2 3 4 5
☐ Pain when Chewing	1 2 3 4 5

Sleep Breathing Complaints

☐ CPAP Intolerance	1 2 3 4 5
☐ Difficulty Falling Asleep	1 2 3 4 5
☐ Difficulty Staying Asleep	1 2 3 4 5
☐ Fatigue	1 2 3 4 5
☐ Frequent Heavy Snoring	1 2 3 4 5
☐ Frequent Heavy Snoring which affects the sleep of others	1 2 3 4 5
☐ Frequent Nighttime Urination	1 2 3 4 5
☐ Gasping when Waking up	1 2 3 4 5
☐ Morning Headaches	1 2 3 4 5
☐ Nighttime Choking Spells	1 2 3 4 5
☐ Significant Daytime Drowsiness	1 2 3 4 5
☐ Sleepy while Driving	1 2 3 4 5
☐ Witnessed Apneic Events	1 2 3 4 5

*Please describe in your own words your **previous attempts to treat your obstructive sleep apnea or TMD and to what extent you are still using any of these treatments**.*

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EPWORTH SLEEPINESS SCALE

In contrast to just feeling tired, how likely are you to doze off or fall asleep in the following situations? Use the following scale to choose the most appropriate number for each situation:

0 = Would never doze
1 = Slight chance of dozing
2 = Moderate chance of dozing
3 = High chance of dozing

SITUATION	
Sitting and reading	_____
Watching Television	_____
Sitting inactive in a public place (i.e. theater)	_____
As a car passenger for an hour without a break	_____
Lying down to rest in the afternoon	_____
Sitting and talking to someone	_____
Sitting quietly after lunch without alcohol	_____
In a car, while stopping for a few minutes in traffic	_____
TOTAL SCORE	_____

A score of 6 or greater indicates the possibility of a sleep breathing disorder.

Patient Signature _____ Date _____

Patient Name (Printed) _____

Assignment of Benefits and Medical Information Release

I authorize the release of a full report of examination findings, diagnosis, treatment program, etc. to any referring or treating dentist or physician. I additionally authorize the release of any medical information to insurance companies or for legal documentation to process claims. I authorize assignment of insurance benefits to Dr. Lonn Brander, DDS for medical services and/or supplies furnished to me by Dr. Lonn Brander, DDS. I agree to pay all amounts that are not covered by my insurer(s) including applicable co-payments and/or deductibles for which I am responsible.

Patient Signature _____ Date _____

Patient Name (Printed)

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Sleep Observer's Scale

(Bed Partner to complete)

Before oral appliance date: _____
After oral appliance date: _____

Patient: _____ DOB: _____
Observer: _____ Relation: _____

0 = Never **1= Infrequent** One night/week **2 = Frequent** 2-3 nights/week **3 = Most of the time** 4 or more nights/week

	Before OA	After OA
1 – Light snoring		
2 – Loud, disruptive snoring		
3 – Snoring requiring separate bedrooms		
4 – Occasional loud snorts		
5 – Choking, gasping for air		
6 – Breathing pauses or stops		
7 – Twitching, kicking arms and/or legs Occurs every 10-20 seconds: Y/N		
8 – Awaking with pain		
9 – Sleepwalking		
10 – Shaking or Rocking		
11 – Becomes very rigid		
12 – Sitting up in bed while sleeping		
13 – Teeth Grinding		
14 – Doing unusual activity while sleeping		

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15 – Bedwetting		
16 – Falling asleep at inappropriate times, i.e., while driving		
17 – Other:_____		
TOTAL SCORE:		

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AFFIDAVIT FOR INTOLERANCE TO CPAP

NAME_____

I have attempted to use nasal CPAP to manage my sleep related breathing disorder (apnea) and find it intolerable to use on a regular basis for the following reasons(s):

_____Mask leaks

_____Unable to get the mask to fit properly

_____Mask uncomfortable / Device uncomfortable

_____Unable to sleep comfortably

_____Noise disturbs my sleep and/or bed partner's sleep

_____Restricts movement during sleep

_____Does not seem to be effective

_____Straps / headgear cause discomfort

_____Pressure on the upper lip cause tooth related problems

_____Latex allergy

_____Claustrophobic associations

_____An unconscious need to remove CPAP

_____Other: _____

Because of my intolerance/inability to use CPAP, I wish to have an alternative method of treatment. That form of therapy is an Oral Sleep Appliance.

Signed_____

Date_____