TMJ & SLEEP APNEA QUESTIONNAIRE

Patient Name _____ Date _____

TMJ Questions:

Do you get headaches/migraine headaches?	**Y or N**
Have you had chronic shoulder or back pain?	**Y or N**
Are your jaws tired or teeth sore when you awaken?	**Y or N**
Have your wisdom teeth been extracted?	**Y or N**
Have you had a severe blow to the head or jaw?	**Y or N**
Any whiplash neck injuries?	**Y or N**
Does your jaw get tired after a big meal?	**Y or N**
Do you ever feel dizzy, nauseated or faint?	**Y or N**
Do you have pain in either ear?	**Y or N**
Do you suffer from loss of hearing?	**Y or N**
Do you have itchiness or stuffiness in either ear?	**Y or N**

Sleep Apnea Questions:

Do you have trouble sleeping soundly?	**Y or N**
Do you snore at night?	**Y or N**
Do you feel fatigued during the day?	**Y or N**
Do you wake up feeling like you haven't slept?	**Y or N**
Have you been told you stop breathing at night?	**Y or N**
Do you gasp for air or choke while sleeping?	**Y or N**
Do you have high blood pressure?	**Y or N**
Do you take medication for high blood pressure?	**Y or N**

Do you frequently have neck aches or stiff neck muscles?	**Y or N**
Do you hear ringing, buzzing, or hissing sounds in either ear?	**Y or N**
Do you hear a "clicking" or "popping" noise in either jaw joint	**Y or N**
Has your jaw ever locked when you were unable to open or close?	**Y or N**
Do you have difficulty opening wide or have jaw pain from yawning?	**Y or N**
Is your nose stuffed when you do not have a cold?	**Y or N**
Do you have family history of jaw joint problems or headaches?	**Y or N**

TAKE HOME SLEEP STUDY CONSENT: (If recommended)

I acknowledge that I am receiving the Home Sleep Test Device to complete a one night, in home sleep test. I understand that this equipment is only on loan to me and must be returned to Sullivan Dental Center the next morning no later than 9:00 a.m. I am responsible for loss or damage to the equipment while it is in my possession. It is my responsibility to return the equipment and all related components upon completion of the home study. Should I fail to return the device and all related components in the condition in which they were received, I agree to pay Sullivan Dental Center the fee for replacing devices which have been lost, damaged, or not returned, of up to $4,000. **Agreement to these terms is evidenced by my signature.**

SIGNATURE: _____ **Date** _____