ZWEIG FAMILY DENTISTRY
Your Family's Path to Dental Health

TMJ AND SLEEP SCREENING FORM

Check all that apply:

- ☐ Frequent Snoring
- ☐ Sleep Apnea
- ☐ Daytime Fatigue
- ☐ Told that I "stop breathing" during sleep
- ☐ Headaches and/or Migraines
- ☐ Ear Congestion
- ☐ Pain Behind the Eyes
- ☐ Vertigo (dizziness)
- ☐ Tinnitus (ringing in the ears)
- ☐ Limited Mouth Opening
- ☐ Neck, Shoulder or Back Pain and/or
- ☐ Stiffness
- ☐ Loose Teeth
- ☐ Clenching / Bruxing
- ☐ Clicking or Grating Sounds in Jaw Joint(s)
- ☐ Pain or Soreness of Jaw Joint(s)
- ☐ Locking Jaw (opened or closed)
- ☐ Tender, Sensitive Teeth
- ☐ Thermal Sensitivity (hot or cold)
- ☐ Difficulty Chewing
- ☐ Difficulty Swallowing
- ☐ Trigeminal Neuralgia
- ☐ Bell's Palsy
- ☐ Postural Problems
- ☐ Tingling or Numbness in Fingers or Arms
- ☐ Nervousness / Insomnia

THE EPWORTH SLEEPINESS SCALE

How likely are you to doze off or fall asleep in the following situations?

☑ Check one in each row:	0 No chance of dozing	1 Slight chance of dozing	2 Moderate chance of dozing	3 High chance of dozing
Sitting and reading	☐	☐	☐	☐
Watching TV	☐	☐	☐	☐
Sitting inactive in a public place (i.e., a theater or a meeting)	☐	☐	☐	☐
As a passenger in a car for an hour without a break	☐	☐	☐	☐
Lying down to rest in the afternoon when circumstances permit	☐	☐	☐	☐
Sitting and talking to someone	☐	☐	☐	☐
Sitting quietly after a lunch without alcohol	☐	☐	☐	☐
In a car, while stopping for a few minutes in traffic	☐	☐	☐	☐

Total Score: _____ (Add Columns 0-3)

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