

TMJ AND SLEEP SCREENING FORM

Check all that apply:

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

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

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

Total Score: _____ (Add Columns 0-3)