Louly Dentistry Inc.

Sleep History/Exam/Workup Exam

Name_____ Date ___/___/_____

Date of birth ___/___/_____ Sex: M___ F___

Vital Data

Blood pressure_____ Neck measurement (inches)_____

Pulse_____

Body Mass Index

Height: Weight (lbs.)_____ BMI_____

Oral Examination Revealed

Within normal limits___

Dental

Prosthesis present (specify type) _____

Adequate Number of teeth to support oral device Y N

Malocclusion (specify)

Edge-to-edge malocclusion: Teeth #_____

Crossbite: Teeth #_____

Occlusion

___Overjet ___Overbite

Periodontal

YES NO

Dental Relationship

Class

___1 (normal) ___2 (retrognathic) ___3 (prognathic)

Airway Evaluation

Examination of tongue showed:

___Ankyloglossia (tongue-tie) ___Enlarged ___Scalloped ___Tongue thrust

Mallampati Classification

___Class 1 ___Class 2 ___Class 3 ___Class 4

Tonsils

___Absent ___Present

___Grade 0 ___Grade 1 ___Grade 2 ___Grade 3 ___Grade4

Uvula

___Elongated ___Enlarged

___Absent ___Obstructs airway

Soft Palate

___Obstructs airway ___Within normal limits

Maxilla

___Moderately Vaulted ___Vaulted ___Edentulous ___Partially edentulous

Tori Y N

Mandible

___Narrow ___Micrognathia ___Edentulous ___Partially edentulous

Tori Y N

Range of Motion

Maximum interincial opening_____ Maximum protrusive_____

Left lateral excursion_____ Right lateral excursion_____

Deviation to left_____ Deviation to right_____

Deflection to left_____ Deflection to right_____

___Normal mandibular midline ___Normal maxillary midline

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Social History

Patient's occupation: _____

Tobacco use: Never smoked___ Current smoker___ Quit___

# of packs per day___ When?_____

# of years___

Other tobacco: Pipe___ Cigar___ Huff___ Chew___

Caffeine intake: None___ Coffee/Tea/Soda___ (# of cups per day)___

Regular exercise___

What are the main complaints for which you are seeking treatment?

Please **number** your complaints with #1 being the most sever, #2 the next most sever, etc.

Number

___CPAP intolerance
___Difficulty concentrating
___Excessive daytime sleepiness
___Fatigue
___Forgetfulness
___Frequent snoring
___Gasping causing waking up

Number

___Impaired thinking
___Insomnia
___Morning headaches
___Nighttime choking spells
___Snoring that affects the sleep of others
___Witnessed cessation of breathing

Other:_____

CPAP Intolerance

If you have attempted treatment with a CPAP device, but could not tolerate it please fill in this section

___Refuses CPAP
___Claustrophobic associations
___CPAP restricted movement
___Inability to make mask fit properly
___Headgear discomfort
___Noisy
___Latex allergy
___Noise disturbing sleep and/or bed partner's sleep
___Mask leaks
___Unconscious need to remove the CPAP
___CPAP not effective
___Pressure on upper lip causing teeth problems
___Disturbed or interrupted sleep
___Cumbersome

Other:_____

Other Therapy Attempts

___Dieting
___Uvulectomy
___Pillar procedure
___BiPAP
___Uvuloplasty
___Nasal strips
___Weight loss
___Positional therapy
___Smoking cessation

Other:_____

Patient Signature

Because of HIPAA Federal regulations protecting your privacy, we wish to inform you that we will release no information about you without your consent. By agreeing to this consent, you permit the release of any information to or from your dental practitioner as required including a full report of examination findings, diagnostics and treatment program to any referring or treating dentist or physician, You understand that you are financially responsible for all charges whether or not paid by insurance. Your dental practitioner may use your health care information and may disclose such information to your Insurance Company(ies) and their agents for the purpose of obtaining payment for service and determining insurance benefits or the benefits payable for related services. I certify that my medical history is complete and accurate.

Patient signature _____ Date: ___/___/_____

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Sleep Disordered Breathing Assessment

Is the patient a candidate for oral appliance therapy (OAT)? Y N

___There is insufficient denition

___The patient decided against oral appliance therapy and would like to try other options

Today's Procedures

Impression Taken

Impression taken for fabrication of_____

TAP Gauge V___ H___

Appliance Delivery Exam

Oral Appliance Delivery

Appliance design:_____

Appliance delivery date ___/___/_____

Appliance fit: ___Appliance was fitted

___Good upper/lower fit

Adjustment needed: ___None

___Loosen upper

Treatment Plan

___We will continue to evaluate the patient's mandibular position until follow up sleep study confirm efficacy.

___Evaluate and calibrate oral device as comfort allows until maximum improvement is achieved .

___Evaluation in _____ weeks and refer for follow up sleep study to confirm efficacy

___Refer for a sleep study for follow-up to confirm efficacy or to adjust the oral appliance when subjective results suggest improvement of symptoms.

___Scheduling patient for periodic office visits once maximum improvement had been verified, with instructions to continue with their periodic physician office visits.

Other:_____

Next Appointment

We would like to see the patient in _____ ___Days ___Weeks ___Months ___Years

RECORD OF SERVICES

DATE	TOOTH #	SUR-FACE	SERVICES RENDERED	PROD. NO.	SERVICE CODE	FEE	RECALL DATE