SnoringSolutionsNI
ADJUSTABLE PRECISION ANTI-SNORING APPLIANCES

# PRE-CONSULTATION QUESTIONNAIRE

**Please answer all questions and bring this form with you to the consultation.**

Surname Name Date of Birth

Address Postcode

Telephone Mobile Email

General Medical Practitioner (Doctor)

Dentist

**This is a pre-assessment screening questionnaire. It provides important baseline information which will be treated in strict confidence.**

**What is your main concern or that of your sleeping partner?** Please circle

| | | | | | |
|---|---|---|---|---|---|
| Snoring | **Yes** | **No** | Bruxism / Tooth Grinding | **Yes** | **No** |
| Sleep Apnoea | **Yes** | **No** | Temperomandibular Jaw Joint (TMD) pain | **Yes** | **No** |

| | | | | |
|---|---|---|---|---|
| Do you snore?<br>If yes, please circle | **YES**<br>**QUITE** | **NO**<br>**LOUD** | **VERY LOUD** | **DEAFENING** |
| Do you have daytime sleepiness? | **YES** | **NO** | | |
| Shared or separate bedrooms? | **SHARED** | **SEPARATE** | | |
| Do you habitually sleep on your back? | **YES** | **NO** | | |
| Does your jaw fall open during sleep? | **YES** | **NO** | | |
| Do you awake from sleep feeling choked? | **YES** | **NO** | | |
| Do you have trouble breathing through your nose at night? | **YES** | **NO** | | |
| Has anyone noticed you stop breathing whilst asleep? | **YES** | **NO** | | |
| Do you awake at night to pass water?<br>How often? | **YES**<br>**1** | **NO**<br>**2-3** | <br>**4+** | |
| Do you have a dry mouth or throat in the morning? | **YES** | **NO** | | |
| Do you suffer from headaches in the morning? | **YES** | **NO** | | |

What time do you usually go to sleep?

What time do you wake up?

What is your collar size now?

What was your collar size 5 years ago?

What is your weight now?

What was your weight 5 years ago?

Weekly alcohol intake

**Units:**

Daily cigarette intake

**Per day**

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**Please list any medical conditions:**

**Or past operations:**

Do you have temperomandibular joint problems (TMD)? **Yes** **No**

Do you suffer from tinnitus? **Yes** **No**

Do you have any allergies?

**Please list any medications being taken:**

| Medication | Dose |
|---|---|
| | |
| | |
| | |

**Height** (metres) **Weight** (kilos) **BMI** **BP** **Epworth score**

**Previous efforts to treat sleep disorder:**

Conservative regimens (e.g. weight loss, exercise):

Mandibular advancement devices:

Nasal continuous positive airway pressure (CPAP): Surgery:

Previous sleep study: YES / NO When? Where? (AHI)

Snoring commonly follows partial closure of the airway, normally at the back of the throat, during sleep. However it may be accompanied by obstructive sleep apnoea (OSA) which is a more serious and potentially life threatening condition. This and other screening questionnaires are used to help identify patients at risk but are not a definitive diagnosis for OSA. The diagnosis of OSA would require you to undergo an overnight sleep study. Severe OSA should be managed within a multidisciplinary team led by a chest physician.

Dental jaw posturing appliances have been shown to be effective in the management of snoring and/or mild OSA. The treatment will not cure the condition but works by holding the jaw in a forward postured position. This leads to an improvement in the airway space. To work, the clinical instructions supplied must be followed, the appliances must be worn during sleep and if not worn, the symptoms will return.

The response to this treatment varies and no guarantee in improvement of your condition can be given. With time, the symptoms may return as the body changes and adapts. Following the initial fitting, excessive salivation and some slight changes in sensation are to be expected. The teeth, bite, facial muscles and jaw joints may feel different. This usually settles.

There is a risk that with long term use, there may be permanent tooth movements or permanent jaw changes. Reporting any problems, especially those listed in the appliance care document, attending the post treatment assessment and regular follow-ups are recommended.

A high standard of mouth care is essential and must be maintained otherwise the appliances could damage the teeth and supporting structures.

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## PATIENT CONSENT:

I understand the questions being asked and have given honest and accurate responses. It has been explained to me that I would need an overnight sleep study to conclusively diagnose obstructive sleep apnoea. I have read the information supplied and understand that the Mandibular Advancement (anti-snoring) Appliance may help manage my condition.

Patient's name _____

Patient's signature _____

Date _____