

Patient #4

Section #2

9/6/07

Sleep questionnaire

Physical examination

Treatment plan



Snoring & Sleep Apnea Wellness Centers

Sleep Apnea Questionnaire:

Date 9-6-07

Patient information:

Last Name _____ First Name _____ MI _____ Male Female
 Date of Birth 7/11/56 Age 51
 Home Address _____ City _____ State WI Zip Code 53130
 Phone Day 414-_____ Evening 414-_____ Cell 414-_____ Email _____
 Driver's License Number _____ Social Security Number _____

Employer information:

Employer (or School) Name _____ MEDICAL TECHNOLOGIST
 (your position / job or school grade level)
 Employer's Street Address _____
 City _____ State _____ Zip Code _____ Employer Phone Number _____

Marital Status:

Single Married Divorced Domestic partner
 If married, Spouse's Name _____
 Spouse's Employer ACL CABS

Emergency contact information: (who should we contact in the event of an emergency?)

Name _____ Relationship to Patient WIFE
 Home Phone _____ Cell Phone _____

Patient Health Information:

1. Problems / concerns prompting this consultation:

<input checked="" type="checkbox"/> Snoring	Observed to choke or gasp for air during sleep	Daytime drowsiness
<input checked="" type="checkbox"/> Fall asleep easily	Poor sleep	Not rested after sleeping
Unable to use/tolerate CPAP	Surgery for sleep apnea/snoring didn't help	A doctor suggested the appointment
Choose not to use the CPAP	Family/friend suggested the appointment	
Other: _____		

2. Please circle any of the following that you have had or have at present:

Heart disease	Prolonged bleeding	Kidney trouble	Drug addiction
Chest pains	Anemia	Liver disease	Undiagnosed joint pain
High blood pressure	Arthritis	Hepatitis	Rheumatoid arthritis
Artificial heart valve	Asthma	Thyroid disease	Cancer / chemotherapy / radiation
Heart murmur	Emphysema	Glaucoma	Tumors / cysts
Rheumatic fever	Tuberculosis (TB)	Lung disease	Epilepsy
Congenital heart defect	Stroke	Seizures	Reflux
Hemophilia	Ulcers	High cholesterol	Diabetes
Sinus problems	Glaucoma	HIV/AIDS	Excessive thirst
Fainting	Eating disorder	Psychiatric care	Sexually transmitted disease
Chemical dependency	Depression	Implants (any type)	Latex allergy
Other condition(s)/disorder(s) not listed: _____			

3. Family History: Circle any of the following that a family member has or had (mother/father/brother/sister/grandparents)

Migraines Snoring Sleep Apnea TMJ Arthritis Cancer Diabetes Heart Attack Stroke
 Other Sleep Disorder: (explain) _____

4. List all medications (prescriptions, over the counter medicines, herbs, vitamins, etc) or, attach a list of your medications to this form

Ibuprofen - occasional headaches (2x/month)
Multi Vitamin
Aspirin - heard it was good for his heart *(L.S.M.)*

5. List any allergies (medications, materials, etc.) and type of reaction (i.e., rash, itching, breathing difficulty, etc.)

- | | Yes | No |
|--|-----------|-------|
| 6. Do you smoke?
If yes, pack(s) per day _____ for how many years _____ | 6. _____ | X |
| 7. Do you drink alcohol?
If yes, how many drinks? <u>3</u> per week OR, _____ per month | 7. _____ | _____ |
| 8. Females: Are you pregnant? If yes circle the trimester 1 2 3 | 8. _____ | _____ |
| 9. Do you use sleeping pills at anytime? | 9. _____ | X |
| 10. Has anyone in your family been diagnosed with sleep apnea or snoring? | 10. X | _____ |
| 11. Do you snore? | 11. X | _____ |
| 12. Does your snoring disturb others | 12. _____ | X |
| 13. Are you tired or groggy during the day? | 13. _____ | X |
| 14. Are you refreshed after sleeping 7-10 hours? | 14. X | _____ |
| 15. Do you fall asleep easily? | 15. X | _____ |
| 16. How long does it take to fall asleep in bed each night? about <u>2</u> minutes | 16. _____ | _____ |
| 17. Do you wake frequently during the night? | 17. _____ | X |
| 18. Average number of hours of sleep per night <u>6-7</u> | 18. _____ | _____ |
| 19. Are you frequently sleepy when driving? | 19. _____ | X |
| 20. In the recent past have you had auto or work related accidents? | 20. _____ | X |
| 21. Have you been observed to choke, gasp or hold your breath when sleeping? | 21. _____ | X |
| 22. Have you ever wakened yourself choking, gasping for air or out of breath? | 22. _____ | X |
| 23. Do you sometimes have headaches when waking in the morning? | 23. X | _____ |
| 24. Have you noticed difficulty concentrating or focusing on tasks? | 24. _____ | X |
| 25. Do you have difficulty exercising because of fatigue? | 25. _____ | X |
| 26. Are you "active" during sleep (frequent moving, turning, thrashing, kicking)? | 26. _____ | X |
| 27. Do you have difficulty breathing through your nose at night? | 27. _____ | X |
| 28. Have you ever had a sleep study? | 28. X | _____ |

If yes, Sleep lab name: _____ Dr. _____

Location of sleep lab: Milwaukee When performed: 1/22/01

29. Height: 5 feet 10 inches Weight: 190 pounds

30. Neck/collar size 16 inches

31. Circle all of the past treatments that have been tried for your sleep apnea:

- CPAP Throat Surgery (UPPP) Jaw Surgery
Weight Loss Sleep Position Changes Dental Appliances / Splints

Other: _____ Which treatments are you still using? CPAP Sometimes

32. Why did you stop any above treatments? Jaw splint broke

33. Circle all areas that you have had pain in the past 6 months?

- | | | | | | |
|------------------|-------|------------------|-----------|------------------|--------|
| TMJ | Teeth | Temples | Jaws | Face | Throat |
| Neck | Ears | Inside the mouth | Headaches | Morning jaw pain | |
| Other pain _____ | | | | | |

34. Do you have TMJ (jaw joint) noises when opening or closing? (pop, click, crunch, grind, etc.) 34. _____ X

Past treatment(s) for TMJ _____
 Past mouth splints/nightguards _____
 Trauma to face / jaw _____
 Fractures to jaw / face _____

*Does not like
 his CPAP
 L.S.M.*

35. Have you been diagnosed with fibromyalgia or other chronic pain conditions? 35.
 If yes, explain _____

Dental:

36. Have you in the past, or, are you now working with an orthodontist? 36.
 Dr. _____ When completed _____

37. Did you, or will you, have jaw surgery as part of your orthodontics? 37.
 Dr. _____ When _____

38. Are you currently under dental care? 38.
 Last dental check-up? (date) June 2007 _____

39. Do you have any pending dental work? 39.
 If yes, explain deep cleaning next week

40. Do you have any dental implants? 40.

41. Do you have any crowns or bridges? 41.

42. Do you an upper and/or lower full denture? 42.

43. Do you have an upper and/or lower partial denture? 43.

44. Do you have any problems with dental prosthesis (crowns, bridges, partial dentures, implants)? 44.
 If yes, explain _____

45. Do you now or have you had periodontal (gum) disease? 45.

46. Do you have any loose teeth? 46.

47. Have you been told that you clench or grind your teeth during sleep? 47.

48. Do you have or have you been treated for bruxism (grinding of the teeth)? 48.

49. Have you had treatment for worn down teeth? 49.

50. Have you ever fractured teeth? 50.
 If yes, how _____

51. Have you had teeth removed? 51.
 If yes, what was the reason wisdom teeth

52. Have you had other dental surgery? 52.
 If yes, explain Gum Surgery 15 years ago

53. Any other dental problems not already noted? 53.
 If yes, explain _____

54. Please rate how likely you are to doze off or fall asleep in the following situations. Use the scale to rate how likely you are to fall asleep with each particular activity. Even if you have not been in that situation lately estimate how it would likely affect you.

Sitting and reading	<u>1</u>
Watching TV	<u>1</u>
Sitting inactive in a public place (theater, meeting, library)	<u>1</u>
As a passenger in a car for an hour without a break	<u>0</u>
Lying down to rest in the afternoon	<u>1</u>
Sitting and talking to someone	<u>0</u>
Sitting quietly after lunch (without alcohol)	<u>0</u>
In a car, while stopped for a few minutes in traffic	<u>0</u>
TOTAL	<u>4</u>

Scale
 0 - would never doze
 1 - Slight chance of dozing
 2 - Moderate chance of dozing
 3 - High chance of dozing

Please initial beside each doctor's name that you allow us to send a report.

61. Referring Doctor: _____ STK initial here to allow a report to be sent to this doctor
 Office name / Address: _____

Phone: _____

62. Sleep clinic doctor: _____ STK initial here to allow a report to be sent to this doctor
 Office name / Address: _____

Phone: _____

63. Primary Doctor: _____ STK initial here to allow a report to be sent to this doctor
 Office name / Address: _____

Phone: _____

64. Primary Dentist: _____

Office name / Address: _____

SJK initial here to allow a report to be sent to this doctor

Phone: _____

65. Other Physician or Dental specialist you are seeing for this problem: _____

Office name / Address: _____

_____ initial here to allow a report to be sent to this doctor

Phone: _____

66. Other Physician or Dental specialist: _____

Office name / Address: _____

_____ initial here to allow a report to be sent to this doctor

Phone: _____

Any other Physicians, Dentists or locations you would like a copy of a report sent to:

67. Name: _____

Office name / Address: _____

_____ initial here to allow a report to be sent to this person

Phone: _____

68. How did you hear about us?

<input checked="" type="checkbox"/>	Doctor listed in # 61 above	<input type="checkbox"/>	Friend / Family member *
<input type="checkbox"/>	Insurance book	<input type="checkbox"/>	One of our office staff/employees *
<input type="checkbox"/>	Newspaper	<input type="checkbox"/>	Sign
<input type="checkbox"/>	Radio	<input type="checkbox"/>	Magazine
<input type="checkbox"/>	Healthwise publication	<input type="checkbox"/>	Television
<input type="checkbox"/>	Yellow pages	<input type="checkbox"/>	Coupon

Other: _____

*If you heard about us through a friend, family member, or one of our office staff/employees, whom may we thank?

Name: _____

Address: _____

Phone #: _____

Note: If medications are prescribed at anytime, it is our policy that we can NOT replace any lost, stolen, or accidentally destroyed medications / prescriptions.

"I have read, understand and completed this questionnaire to the best of my ability. I have answered all questions honestly and completely."

[Signature]
Patient signature

September 6th 2007
Date

Name: [REDACTED]
Chart # 9000243

Date: 7/11/06 9/16/07
DOB: 7/11/56 RSM

SNORING / SLEEP APNEA PHYSICAL EXAMINATION

Diagnosis from PSG:

- Primary snoring
- Mild sleep apnea
- Moderate sleep apnea
- Severe sleep apnea
- UARS
- Narcolepsy
- PLM
- RLS
- Sleep Deprived
- Other SDB

No PSG, Differential dx:

- Primary snoring
- Sleep Apnea
- Other SDB
- No sleep disorder
- Insomnia
- Narcolepsy
- PLM
- RLS
- Fibromyalgia
- Other

Other dx:

- TMJ disc displaced with Reduc
- TMJ disc displac without Red
- TM joint osteoarthritis
- MFDP / Fibromyalgia
- Caries
- Nonrestorable
- Has Com Dtr - Max / Man
- Has RPD
- Micrognathia
- Microsomia
- Retrognathia - Max / Man
- Other

Notes:

Treatment performed today:

- Snoring / Sleep apnea screening / risk assessment
- Sleep apnea physical examination
- Primary snoring physical examination
- Impressions for sleep apnea device
- Impressions for snore device
- Reviewed PSG: Dr. [REDACTED] Sleep Lab [REDACTED]
- Other

Orders:

- Impressions BR: George gauge @ 1mm only % Other BR
- Silent Night - snoring
- TAP - II
- TAP - T
- Somnomed
- PM Positioner
- SUAD
- Silencer
- Custom mask / appliance
- EMA
- Other
- PT
- TMD eval
- Other
- Lab:
 - DSG Lab Michigan
 - Airway Labs Dallas
 - Somnomed Dallas
 - EMA California
 - SUAD Michigan/Canada
 - Other
- Other Recommendations:
 - Weight Loss
 - Avoid supine position (pillow, tennis ball)
 - Increase sleep hours
 - Cognitive behavioral sleep training
 - Other

Radiographs:

- Panograph
- CT airway (with appliance / without appliance)
- TMJ Tomograph
- Lateral cephalometric
- Other
- Vertical BWs
- PA - #
- Occlusal Max / Man

Referrals:

- PSG (lab) Physician
- Dentist
- PMR
- Sleep psychologist
- Other

Medications:

Notes:
- monitor period
- discuss with Dr Wong
- monitor occlusion

Sleep Apnea Examination:

BP: 119/71

Pulse: 74

Respirations: 16

BMI 27

O₂Sat 97%

NC 16 inches

NC (cm) + H (4) + S (3) + C/G (3) = ANC 46
(Hypertension / Snoring / Choking-Gasping)

Patients CC / narrative:

wears CPAP few times a week, mask pulls and leaks, has had multiple mask types.

Takes it off after a few hours.

2 or 3 years ago had a jaw splint made, ^{from} wore maybe a year and then it broke apart. Had NO adjustments at any time.

Doesn't remember the dentist's name (was in Racine).

wants another jaw splint. Easier than the CPAP to wear.

He says he never really falls asleep during the day (ESS-4) but feels tired.

His wife sleeps in a different room. She says he snores even with the CPAP - not sure if he did with the splint he had.

Was referred by his current general dentist when he asked about a replacement sleep splint.

Vertical overbite 5 mm
 Horizontal overjet 3 mm
 Normal shaped/sized arch: Yes / No
 "V shaped arch: Max / Man
 Round arch: Max / Man
 Deep palatal vault: Yes / No
 Tori: Mild

Bilateral posterior open bite, eating well. Used no deprogrammer or bite tabs, had jaw splint over 1yr and "broke"

Crossbite:

Missing teeth (circle): 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16
32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17

MI occlusion (circle): 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16
 (shimstock) 32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17

Crowns (circle): 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16
32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17

FPDs (circle): 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16
32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17

RPDs replacing # (circle): 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16
32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17

Implants (circle): 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16
32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17

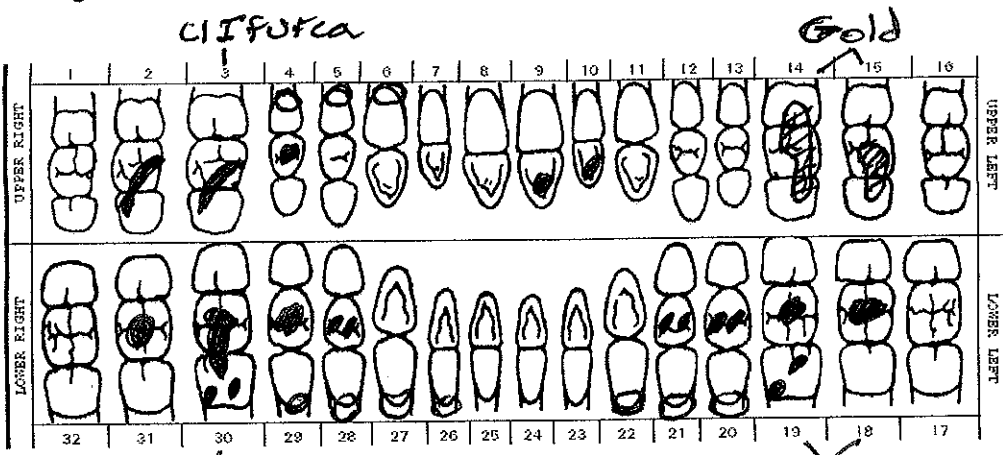
Complete dentures: Max / Man

Nonrestorable teeth: 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16
32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17

can shift/derange lateral & post. to contact 2nd molars

root starting, NO LAMINATED

Charting: Am (black filled) Cmpst (black outlined) Caries (red filled) Fractured (red outlined)



Miller cl. II
 mobility
 #7, 10, 20, 21
 23, 24, 25, 26
 generalized cervical abrasion
 attraction
 defects - some have been repaired

class I furca

class I furca

PSR: 1 1 1
1 2 1

Radiographs:

BWXR date: _____
 FMXR date: _____
 Periapicals date: _____ (# _____)
 Pano scan date: 9/6/2007
 TMJ CT date: 11
 Airway CT date: 11
 Sinus CT date: _____

Radiographic findings:
 Severe Anterior bone loss
 Moderate posterior bone loss.
 MRC Right (medial wall) maxillary sinus
 TRUS TOMOS - NO signif. findings.
 2 perisurg - "clean bone/teeth under the gums"

Extra-oral:

Palpation pain: None R: masseters ___ LPM ___ L: masseters ___ LPM ___
 temporalis ___ MPM ___ temporalis ___ MPM ___
 ant digastric ___ post digastric ___ ant digastric ___ post digastric ___
 frontalis ___
 max sinus ___
 peri-oral ___
 peri-ocular ___

TMJ: None: R: lateral ___ L: lateral ___
 posterior ___ posterior ___
 superior ___ superior ___
 EAM ___ EAM ___

Cervical: None: R: Traps subocc ___ L: Traps subocc ___
 Traps mid ___ Traps mid ___
 Traps shoulder ___ Traps shoulder ___
 Splenius capitus ___ Splenius capitus ___
 SCM mastoid ___ SCM mastoid ___
 SCM mid ___ SCM mid ___
 SCM medial clavicle ___ SCM medial clavicle ___
 SCM lat clavicle ___ SCM lat clavicle ___
 Rhomboids ___ Rhomboids ___
 Scalenes ___ Scalenes ___

Cervical function: Flexion Pain ___ Head: Posture Forward
 Extension Pain ___ side tilt R L ___
 Side Flexion R L Pain ___ other ___
 Rotation R L Pain ___ Shoulders: rounded ___
 Cervical ROM abnormalities ϕ slumped ___
 up & rigid ___
 other ___

TMJ: ROM (passive) 55 mm R: Reciprocal click ___ L: Reciprocal click ___
 ROM (active) ___ mm Opening click ϕ Opening click ϕ
 R: Lateral excursion 14 mm Closing click ϕ Closing click ϕ
 L: Lateral excursion 14 mm Fine crepitus ϕ Fine crepitus ϕ
 Protrusion 12 mm Course crepitus ___ Course crepitus ___

Skeletal:

Class: I II div I ___ II div II ___ III ___
 Mandibular plane angle: Low ___ Normal High ___
 Visual assessment: Maxillae (SNA estimate) ___
 Mandible (SNB estimate) ___

Ceph measurements: (date: 5/28/21) ANB ___ Frankfurt H ___ SNA ___ SNB ___
 Apertognathic: Yes / No *states his bite changed with*
 Long facial appearance: Yes / No *the "jaw spurt"*
 Mouth breather: Yes / No *had no adjustments or follow-up*
 Notes: *with jaw spurt. No titration study*

Intra-oral:

Tooth wear: Anterior: enamel dentin
 Posterior: enamel dentin ___
 Facets: ___
 Excessive wear: ___

Brux facets teeth #s 5/28/21 6/27/21 8/25 9/24 11/22 12/20/21 / / /
 Facets match (max / man) 5/28 6/27/21 8/25 9/24 11/22 12/20/21 / / /

Tongue ridging / buccal mucosa ridging / pronounced linea alba
 Cheek biting / lip biting mild
 Lesions / pathoses / none noted

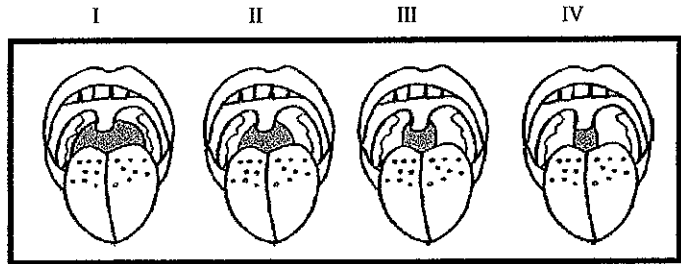
Describe any positive responses: _____

Oral / Oropharynx

Tongue: Sm _____ Md _____ Lg _____ XL

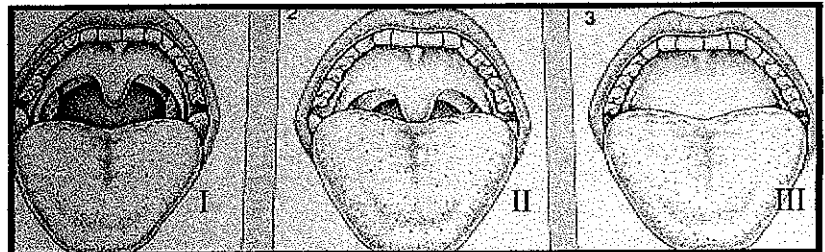
Pharyngeal grade: I _____ II _____ III IV _____

(Sampsoon-Young Classification)



Soft palate: I _____ II III _____

(Mallampati Classification)



Abnormalities / pathoses noted _____

Handwritten note: no surgery (just clean)

Additional Notes:

Previous scaling and root planing, was under periodontist care, now "stable" and has cleanings q 3 mos - [redacted] office. Was with periodontist for yrs.

No BOP today, significant previous attachment loss. Generalized. No mobility of posterior teeth except 20-21 (I-II mobility)

After getting jaw splint (sounds like it was a monobloc?) he never saw the dentist again for flw and no check of effectiveness of splint. Wore it about 1 yr, helped snoring, still wore CPAP "on occasion" and since splint broke (detached?) wore CPAP a little more.

Can not keep CPAP on at night (no 3hrs/night at best) "once or twice" per week he wears CPAP.

Discussed poor periodontium and stresses by the appliances, previous bite changes from monobloc (open posterior bite) and the possibility of grossly changing the bite or losing teeth. Not concerned of current bite, eating well, and will sign consent he understands the problems with his teeth/bone/gingiva. This was added to the consent and signed.