PATIENT OAT FOLLOW UP QUESTIONNAIRE

Patient Name: _____

Date: _____

HT: _____ WT: _____ BP: _____

How are you doing with oral appliance therapy?

_____

Do you have any questions or concerns regarding your therapy?

_____

For each of the following symptoms, please rate your progress using the following:
Some, None, Worse, Same, Better

1. Snoring that you are aware of?_____
2. Snoring that disturbs your bed partner or housemate? _____
3. Waking up gasping for breath? _____
4. Breathing stoppages noticed by bed partner or housemate? _____
5. Coughing/choking in the middle of the night or morning? _____
6. Waking up at night or in the morning with a sour taste or reflux? _____
7. Frequent nighttime urination? _____
8. Excessive movement at night? _____
9. Restless Leg Syndrome (feeling the need to move when still)? _____
10. Nighttime clenching or grinding teeth? _____
11. Vivid dreaming? _____
12. Waking up feeling unrested? _____
13. Daytime sleepiness? _____
14. Forgetfulness/memory problems? _____
15. Difficulty falling asleep at bedtime? _____

Updated Epworth Score

For each of the circumstances below, please rate how likely it would be for you to fall asleep since starting treatment.

0 - Would never fall asleep 1 - Slight chance of dozing
2 - Moderate chance of dozing 3- High chance of dozing

Sitting and reading (even at night)	_____
Watching television	_____
Sitting inactive in a public place (Ex. waiting room, theater)	_____
A passenger in a car for an hour without a break	_____
Lying down to rest in the afternoon when possible	_____
Sitting quietly after lunch without alcohol	_____
Sitting and talking to someone	_____
In a car stopped for a few minutes in traffic	_____

TOTAL SCORE _____

Patient Name: _____

Date: _____

HT: _____ **WT:** _____ **BP:** _____

Have you had any medical visits, medication, or health changes since your last appointment?

_____

How long have you had this oral appliance? _____

Is the appliance still in good condition? YES / NO

Do you use your appliance every night? (If no, why not?) _____

_____

What percentage of your sleep time do you wear your appliance? _____%

Do you find your sleep to be more refreshing? _____

Do you have any tooth tenderness? _____

Do you have jaw soreness or tenderness in the morning? _____

Does your bite feel off in the morning? _____

(If yes) How long does it take to go back to normal? _____

Can you breathe well through your nose at night? _____

Circle how you would rate your progress with your appliance:

Fantastic / Good / Average /Fair / Struggling

(Clinical Team Only) Any adjustments made today / Next steps

_____

_____

_____

_____