Name_____ **Date_____**

Use Of Your Oral Appliance

Do you sleep easily with your oral appliance? Yes No

Do you sleep all night with the appliance in place? Yes No

Do you use your appliance every night? Yes No

Does your appliance fall out at night? Yes No

Has your snoring been reduced? Yes No

Has your excessive daytime sleepiness been reduced Yes No

Do you have tooth tenderness in the morning? Yes No
If yes, how long_____

Do you have jaw joint tenderness in the morning? Yes No
If yes, how long_____

Does your bite feel different in the morning? Yes No
If yes, how long_____

Do you use your bite exerciser every morning? Yes No

Do you notice that you are dreaming more? Yes No

How would you rate your progress with your appliance?
Fantastic Good Average Fair Struggling

How would you rate your overall feeling of well being since starting appliance therapy?
Fantastic Good Average Fair Struggling

Comments you may have regarding your treatment: