



Lthaca Dentistry
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EVALUATION FOR SLEEP DISORDERED BREATHING

Patient's Name: _____ DOB _____ Gender _____

Evaluation for sleep disordered breathing: Sleep deprived patients suffer many of these symptoms due to compromised airway opening. This can result in reduced oxygen, air flow and increased carbon dioxide, swollen tonsils and adenoids, orthodontic problems, brain and immune systems problems. A tongue restriction (tie) can be a contributing factor or the direct cause.

Please indicate the degree of any problems by choosing from the following symptoms severity

0 = not a problem 1 = occasionally 2= moderate 3= significant

- | | |
|--|--|
| 1. ___ Snoring during the night | 16. ___ Aggressive behavior |
| 2. ___ Mouth breathing when sleeping | 17. ___ Irritability and/or anger |
| 3. ___ Mouth breathing during the day | 18. ___ Has had multiple throat infections |
| 4. ___ Waking frequently at night | 19. ___ Gags on foods |
| 5. ___ Wandering all over the bed at night | 20. ___ Is a picky eater |
| 6. ___ Sleep in the teepee position | 21. ___ Dark circles under your eyes |
| 7. ___ Grind teeth at night | 22. ___ Fidgets with your hands |
| 8. ___ Restless sleeper | 23. ___ Bedwetting |
| 9. ___ Talk in your sleep | 24. ___ Excessive sweating during night |
| 10. ___ Signs or diagnosis of hyperactivity | 25. ___ Sleep apnea |
| 11. ___ Fall asleep watching TV | 26. ___ Delayed or stunted growth |
| 12. ___ wake up in the morning with a headache | 27. ___ Sleep walking |
| 13. ___ Does poorly in school (if attending) | 28. ___ Food and texture aversions |
| 14. ___ Diagnosis of ADD or ADHD | 29. ___ Acid reflux |
| 15. ___ Taking any medications for behavior modification | 30. ___ Gap between front teeth |

Do you have any medical conditions? _____

Do you have a bleeding disorder? _____

Are you taking any medications? Yes ___ No ___ (please list medication(s))

Who referred you to our office? _____

Have you been evaluated for tongue or lip ties? Yes ___ No ___ If yes, by who?

Physician: _____ Phone number: _____

Can we send a report to the physician? Yes ___ No ___ please initial _____