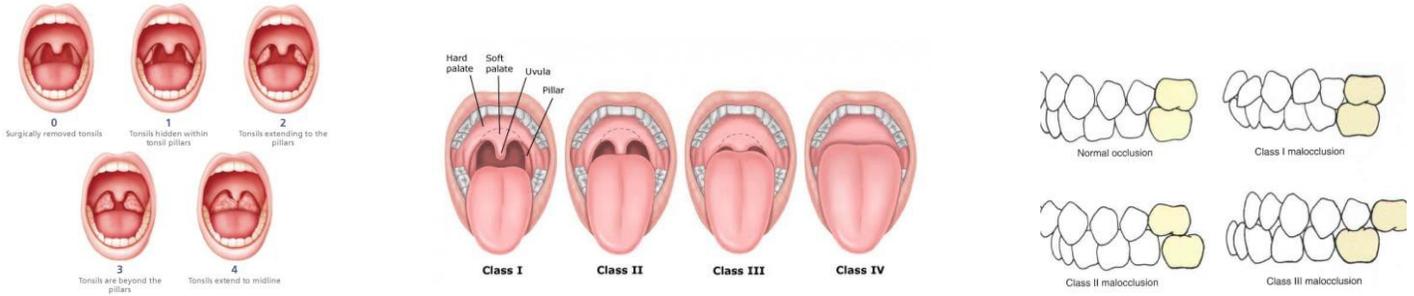


Airway Evaluator



- | | |
|---|--|
| <ul style="list-style-type: none"> <input type="checkbox"/> Clenching/Grinding <input type="checkbox"/> Nasal septum deviation <input type="checkbox"/> Anterior gingivitis <input type="checkbox"/> Periodontal disease <input type="checkbox"/> Battered uvula <input type="checkbox"/> Acid erosion/cupping in cusp area <input type="checkbox"/> Scalloped tongue <input type="checkbox"/> Large tongue <input type="checkbox"/> Tongue tie _____% <input type="checkbox"/> Bags under the eyes <input type="checkbox"/> Turkey waddle <input type="checkbox"/> Pharyngeal walls <input type="checkbox"/> Mouth breathing <input type="checkbox"/> Headaches/when/where | <ul style="list-style-type: none"> <input type="checkbox"/> High arched palate <input type="checkbox"/> Nasal congestion <input type="checkbox"/> Overbite greater than 80% <input type="checkbox"/> Pre-molar extraction <input type="checkbox"/> Abfraction <input type="checkbox"/> Forward wear pattern <input type="checkbox"/> Lingual tori <input type="checkbox"/> Palatal tori/exostoses <input type="checkbox"/> Forward head posture <input type="checkbox"/> Lingualized dentition <input type="checkbox"/> Allergies/Medication <input type="checkbox"/> Gag reflex <input type="checkbox"/> Overclosure |
|---|--|

Sleep Questionnaire

Answer “YES” or “NO” to the following questions (circle Yes or No answers)

- ◇ Y ◇ N 8 Have you ever been told you stop breathing while asleep?
- ◇ Y ◇ N 6 Have you ever fallen asleep or nodded off while driving?
- ◇ Y ◇ N 6 Have you ever woken up suddenly with shortness of breath, gasping or with your heart racing?
- ◇ Y ◇ N 4 Do you feel excessively sleepy during the day?
- ◇ Y ◇ N 4 Do you snore or have you ever been told that you snore?
- ◇ Y ◇ N 2 Have you had weight gain and found it difficult to lose?
- ◇ Y ◇ N 2 Have you taken medication for, or been diagnosed with high blood pressure?
- ◇ Y ◇ N 3 Do you kick or jerk your legs while sleeping?
- ◇ Y ◇ N 3 Do you feel burning, tingling or crawling sensations in your legs when you wake up?
- ◇ Y ◇ N 3 Do you wake up with headaches during the night or in the morning?
- ◇ Y ◇ N 4 Do you have trouble falling asleep?
- ◇ Y ◇ N 4 Do you have trouble staying asleep once you fall asleep?

Score and Risk Factor (Add the points that you have answered “YES”)

Low 0-7	Moderate 8-11	High 12-15	Severe 16+
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