FAMILY DENTAL PRACTICE

OCCLUSAL RISK ASSESSMENT

Welcome to our practice!
This confidential information will help us prepare for your visit.

PATIENT NAME	DATE

DO YOU HAVE PROBLEMS WITH YOUR JAW JOINT (PAIN, SOUNDS, LIMITED OPENING, LOCKING, POPPING)?
DO YOU FEEL LIKE YOUR LOWER JAW IS BEING PUSHED BACK WHEN YOU BITE YOUR TEETH TOGETHER?
DO YOU AVOID OR HAVE ANY DIFFICULTY CHEWING GUM, CARROTS, NUTS, BAGELS, PROTEIN BARS, OR OTHER HARD, DRY FOODS?
HAVE YOUR TEETH CHANGED IN THE LAST 5 YEARS (i.e. BECOME SHORTER, THINNER, OR WORN)?
ARE YOUR TEETH BECOMMING MORE CROWDED OR DEVELOPING MORE SPACES OVER THE LAST 5 YEARS?
DO YOU KNOW YOURSELF TO HAVE MORE THAN ONE BITE?
DO YOU CHEW ICE, BITE YOUR NAILS, USE YOUR TEETH TO HOLD THINGS, OR HAVE ANY OTHER CHEWING/BITING HABITS?
DO YOU CLENCH YOUR TEETH IN THE DAYTIME OR MAKE THEM SORE?
DO YOU HAVE PROBLEMS WITH SLEEP OR WAKE UP WITH SORENESS OR SENSITIVITY IN YOUR TEETH?
DO YOU WEAR OR HAVE YOU EVER WORN A BITE APPLIANCE?
DO YOU CLENCH OR GRIND YOUR TEETH WHEN YOU ARE STRESSED?

STOP HERE!
(Below Portion To Be Completed With Your Dental Hygienist or Dentist)

1. Significant Wear Present Relative to Age?	◯ LOW	◯ MOD	◯ HIGH
2. Load Test?	◯ LOW	◯ MOD	◯ HIGH
3. Constricted Chewing Pattern?	◯ LOW	◯ MOD	◯ HIGH
4. Anterior Wear?	◯ LOW	◯ MOD	◯ HIGH
5. Posterior Wear?	◯ LOW	◯ MOD	◯ HIGH
6. Appliance Therapy Likely?	◯ LOW	◯ MOD	◯ HIGH

OVERALL OCCLUSAL RISK ASSESSMENT ◯ LOW ◯ MODERATE ◯ HIGH

(920) 245-5404 | 1518 Doctors Court Watertown, WI 53094 | FamilyDentalPracticeWatertown.com/

FAMILY DENTAL PRACTICE

OSA ASSESSMENT

Welcome to our practice!
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PATIENT NAME	DATE

This assessment is a tool used to help screen our patients for Obstructive Sleep Apnea (OSA). Overall scores may determine whether further evaluation by a sleep specialist is warranted.

1. **Do you snore loudly?** ◯ YES ◯ NO
2. **Do you often feel tired or sleepy?** ◯ YES ◯ NO
3. **Has anyone observed you stop breathing during your sleep?** ◯ YES ◯ NO
4. **Do you have or are you being treated for high blood pressure?** ◯ YES ◯ NO
5. **Is your Body Mass Index (BMI) above 35kg/m²?** ◯ YES ◯ NO
6. **Are you over the age of 50?** ◯ YES ◯ NO
7. **Is your neck circumference above 16 inches?** ◯ YES ◯ NO
8. **Is your biological sex male?** ◯ YES ◯ NO

Your risk for OSA is HIGH if you answered YES to 3 or more questions above.

EPWORTH SLEEPINESS SCALE

Please indicate your chance of dozing off to sleep in the following situations.
0 = Would **NEVER** doze 1 = **SLIGHT** chance of dozing 2 = **MODERATE** chance of dozing 3 = **HIGH** chance of dozing

Situation	Chance of Dozing
Sitting and reading	◯ 0 ◯ 1 ◯ 2 ◯ 3
Watching television	◯ 0 ◯ 1 ◯ 2 ◯ 3
Sitting inactive in a public place (e.g. a theater or meeting)	◯ 0 ◯ 1 ◯ 2 ◯ 3
As a passenger in a car for an hour without break	◯ 0 ◯ 1 ◯ 2 ◯ 3
Lying down to rest in the afternoon when circumstances permit	◯ 0 ◯ 1 ◯ 2 ◯ 3
Sitting and talking to someone	◯ 0 ◯ 1 ◯ 2 ◯ 3
Sitting quietly after a lunch without alcohol	◯ 0 ◯ 1 ◯ 2 ◯ 3
In a car, when stopped for a few minutes in traffic	◯ 0 ◯ 1 ◯ 2 ◯ 3

TOTAL SCORE: _____

SCORE RESULTS

1-6 Congratulations! You are getting enough sleep
7-8 Your score is average
9+ Very sleepy and should seek sleep assistance

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