

Patient Name _____ Date _____

**POST TREATMENT QUESTIONNAIRE
FOR PATIENTS WEARING DENTAL DEVICE FOR SNORING**

1. How many nights per week do you wear the device? _____
2. What % of your sleep time each night do you leave the device in your mouth? _____
3. Do you tolerate the dental device: **PLEASE CIRCLE**

Very well
Moderately
Slightly
Not well

4. As a result of the dental device, upon awakening are you: **PLEASE CIRCLE**

More rested
About the same
Less rested

5. Have your jaw joint (s) been: **PLEASE CIRCLE**

More Comfortable
The same
Less comfortable

6. In the daytime, have you been: **PLEASE CIRCLE**

Less Sleepy
About the same
More Sleepy

QUESTIONS FOR BED PARTNER

7. The snoring has been: **PLEASE CIRCLE**

Less What % less? _____
The same
More

8. The patient seems to sleep: **PLEASE CIRCLE**

Better
About the same
Worse