

Patients are to complete this questionnaire with their partner at home and then return it to this dental office.

Doctor _____ Patient _____

- | | yes | sometimes | no |
|---|--------------------------|--------------------------|--------------------------|
| 1. Do you snore only when lying on your back?
(please ask your partner, if possible) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Do you snore only when your mouth is open?
(please ask your partner, if possible) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

No anteriorization of the lower jaw with Silent Nite.

No anteriorization of the lower jaw with Silent Nite, eventually a shorter connector must be substituted after a 10-day testing period.

Anteriorization of the lower jaw with Silent Nite necessary or see below.

- | | | | |
|--|--------------------------|--------------------------|--------------------------|
| 3. Do you snore noisily?
(please ask your partner, if possible) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Do you feel tired in the morning? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Do you awake with a headache in the morning? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Do you have problems concentrating for a long time? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Does sleep suddenly overcome you or do you doze off unintentionally during the day? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Did breathing stop at any time during sleep and did you gasp for breath afterwards?
(please ask your partner, if possible) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Indication of obstructive sleep apnea, examination by sleep disorder specialist recommended.
If prescribed, anteriorization of the lower jaw with Silent Nite is necessary.

Obstructive sleep apnea cannot be excluded, examination by sleep disorder specialist recommended.
If prescribed, anteriorization of the lower jaw with Silent Nite is necessary.

Obstructive sleep apnea is probably not present.
Anteriorization of the lower jaw with Silent Nite is necessary.

- | | | | |
|--|--------------------------|--------------------------|--------------------------|
| 9. Do you feel stiffness in the area of the mandibular (jaw) joints? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Do your jaw muscles feel strained or tense in the morning? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Do you grind or grit your teeth?
(please ask your partner, if possible) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Treatment with Silent Nite is contraindicated because it could cause further damage to the mandibular joint.

Before prescribing Silent Nite, it is necessary to find if mandibular joint disease is present.

Mandibular joint disease probably does not exist. Treatment with Silent Nite is indicated.

This questionnaire does not claim to be complete nor does it release the treating doctor from recommending alternative treatment. Patients where an obstructive sleep apnea is suspected should be referred to a sleep laboratory. In this case the efficacy of the Silent Nite should be examined there as well.

This questionnaire was developed by Dr. Hans-Peter Kopp after years of snore research and treatment in Pfalzgrafenstein, Germany.

QUALITY OF YOUR SLEEP

YES

- 1. Do you awake with a morning headache?
- 2. Do you have high blood pressure?
 - a. Is it only elevated in the morning?
- 3. Do you have excessive daytime sleepiness?
 - a. Do you need multiple naps?
 - b. "Drowse-away" while driving?
 - c. Are you fatigued regardless of how many hours you have slept?
- 4. Does anyone complain of your excessive movement while sleeping?
- 5. Does anyone complain about you snoring?
- 6. Does anyone report to you, that you stop breathing and gasp for air while sleeping?
- 7. Does anyone tell you that you "grind" and/or clench your teeth at night?
- 8. Do you awaken with a dry mouth?
 - a. Any history of bleeding gums, gum recession, sensitive teeth or gum therapy or surgery?
- 9. Do you awaken with a "sour" (acid) taste from time to time?