

# SLEEP APNEA, SLEEP-RELATED BRUXISM, TMD EXAMINATION

Patient Name: _____	Exam Date: month day year
Address: _____	Date of Birth: month day year
	Telephone (H): _____
	Telephone (W): _____
Postal/Zip Code: _____	Telephone (Cell): _____

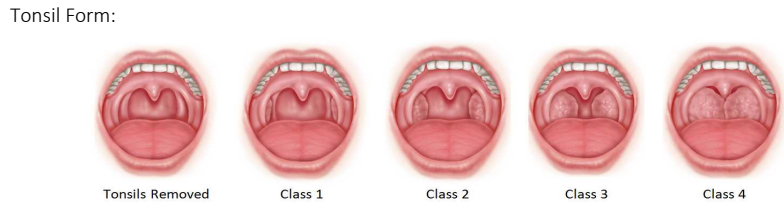
Referred By: \_\_\_\_\_ Sleep Lab: \_\_\_\_\_

Appliances currently worn  CUD  CLD  PUD  PLD  Bruxism upper  Bruxism lower  TMD upper  TMD lower (type) \_\_\_\_\_  
 OSA Type: \_\_\_\_\_  Other appliance: \_\_\_\_\_

Orthodontic Classification:  
 Dental Class I II III n/a Division 0 1 2 Skeletal Class I II III pseudo III  
 Overbite: \_\_\_\_\_ Overjet: \_\_\_\_\_

Dental Alignment:  no crowding  mild crowding  moderate crowding  missing teeth, unstable occlusion SSRI Use?  no  yes

Facial Form:  orthocephalic  bradycephalic  dolichocephalic Linea Alba  no  yes  
 Facial Symmetry:  normal  left side prominent  right side prominent Scalloped Tongue  no  yes  
 Upper Arch Width:  normal  constricted ( mild  moderate  severe)  High Palate Palatal Torus  no  yes (S M L)  
 Cant of Maxilla:  level  left side lower  right side lower Mandibular Tori  no  yes (S M L)  
 AP Tip of Maxilla:  level  incisors lower  incisors higher



Breathing:  nose  mouth  both  
 Unreplaced missing teeth: \_\_\_\_\_ Teeth of concern: \_\_\_\_\_

Contact on closing:  even  incisors  left side  right side  
 Slide into centric:  none  vertically \_\_\_\_\_mm  posterior \_\_\_\_\_mm  left \_\_\_\_\_mm  right \_\_\_\_\_mm  anterior \_\_\_\_\_mm

**TMJ Assessment:**

TMJ Noises		Left	Right
None	Normal	<input type="checkbox"/>	<input type="checkbox"/>
	Restricted	<input type="checkbox"/>	<input type="checkbox"/>
Click	Early	<input type="checkbox"/>	<input type="checkbox"/>
	Intermediate	<input type="checkbox"/>	<input type="checkbox"/>
	Late	<input type="checkbox"/>	<input type="checkbox"/>
Pop	Early	<input type="checkbox"/>	<input type="checkbox"/>
	Intermediate	<input type="checkbox"/>	<input type="checkbox"/>
	Late	<input type="checkbox"/>	<input type="checkbox"/>
Displaced Disk	Closed Lock	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	Creptitation	<input type="checkbox"/>	<input type="checkbox"/>
Capsulitis	Lateral Pole	<input type="checkbox"/>	<input type="checkbox"/>
	Posterior Joint	<input type="checkbox"/>	<input type="checkbox"/>

**Mandibular Range of Motion:**

Range of motion	mm	Pain left?		Pain right?	
Wide opening		<input type="checkbox"/> myo	<input type="checkbox"/> tmj	<input type="checkbox"/> myo	<input type="checkbox"/> tmj
Left		<input type="checkbox"/> myo	<input type="checkbox"/> tmj	<input type="checkbox"/> myo	<input type="checkbox"/> tmj
		<input type="checkbox"/> myo	<input type="checkbox"/> tmj	<input type="checkbox"/> myo	<input type="checkbox"/> tmj
Right		<input type="checkbox"/> myo	<input type="checkbox"/> tmj	<input type="checkbox"/> myo	<input type="checkbox"/> tmj
Protrusion		<input type="checkbox"/> myo	<input type="checkbox"/> tmj	<input type="checkbox"/> myo	<input type="checkbox"/> tmj

Deviation on Protrusion:  none  to left \_\_\_\_\_  to right \_\_\_\_\_

Mandibular tremor present:  no  yes

Coordination of Movement:  normal  mild loss  moderate loss  dyskinesia

**Muscular Assessment:**

**Periodontal Health:**

Muscle Group	Left	Right
Temporalis	0 1 2 3 4 5 TP	0 1 2 3 4 5 TP
Masseter	0 1 2 3 4 5 TP	0 1 2 3 4 5 TP
Medial Pterygoid	0 1 2 3 4 5 TP	0 1 2 3 4 5 TP
Lateral Pterygoid	0 1 2 3 4 5 TP	0 1 2 3 4 5 TP
Sphenomandibularis	0 1 2 3 4 5 TP	0 1 2 3 4 5 TP
Posterior Digastric	0 1 2 3 4 5 TP	0 1 2 3 4 5 TP
Anterior Digastric	0 1 2 3 4 5 TP	0 1 2 3 4 5 TP
Sternocleidomastoid	0 1 2 3 4 5 TP	0 1 2 3 4 5 TP
Scalene	0 1 2 3 4 5 TP	0 1 2 3 4 5 TP
Upper Trapezius	0 1 2 3 4 5 TP	0 1 2 3 4 5 TP

**PSR Scoring** 0 = no pocket  
 1 = 1-2mm pocket  
 2 = 3-4mm pocket  
 3 = 4-5mm pocket  
 4 = 5+ mm pocket

UR	UA	UL
LR	LA	LL

Periodontal referral/therapy needed  
 SSRI/SSNRI Use

