

## YOUR SLEEP EVALUATION

- |   | <b>CIRCLE</b> |   |
|---|---------------|---|
| 1. Do you snore?                                    | Y             | N |
| 2. Do you experience excessive daytime sleepiness?  | Y             | N |
| 3. Do you frequently have morning headaches?        | Y             | N |
| 4. Have you ever had a sleep study?                 | Y             | N |
| 5. Have you been diagnosed with sleep apnea?        | Y             | N |
| 6. Have you ever worn a CPAP device while sleeping? | Y             | N |
| If yes: Is your CPAP comfortable?                   | Y             | N |
| Do you use it every night?                          | Y             | N |
| Do you remove your CPAP during the night?           | Y             | N |
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## YOUR SMILE EVALUATION

- |   | <b>CIRCLE</b>                  |                     |
|---|--------------------------------|---------------------|
| 1. Are you pleased and confident with the way your teeth look when you smile?     | Y                              | N                   |
| 2. Do you have some unwanted spaces or gaps between your teeth?                   | Y                              | N                   |
| 3. Is there a chip or crack that you would like to have repaired?                 | Y                              | N                   |
| 4. Are you concerned about one or perhaps more than one tooth that is discolored? | Y                              | N                   |
| 5. Maybe you have some unattractive discolored metal or plastic fillings?         | Y                              | N                   |
| 6. Do you have teeth that are slightly out of line, overlapping, or protruding?   | Y                              | N                   |
| 7. Do you have some missing teeth that should be replaced?                        | Y                              | N                   |
| 8. Could your smile be improved if your teeth were...                             | Whiter?<br>Longer?<br>Shorter? | Wider?<br>Narrower? |

