

APPENDICES

Appendix 1: Sleep questionnaire as routinely used in the sleep laboratory

NAME: _____ DATE: _____ / _____ / _____

FIRST NAME: _____ SEX: M / F

DATE OF BIRTH: _____ / _____ / _____ AGE: _____

ADDRESS: _____

TELEPHONE: HOME: _____ WORK: _____

PROFESSIONAL SITUATION: _____
(or previous job)

MARITAL STATUS: single / married / living together

FAMILY DOCTOR (+address): _____

SPECIALIST: _____ SPECIALTY: _____

REASON FOR REFERRAL TO SLEEP ANALYSIS: _____

PLEASE ANSWER EACH FOLLOWING QUESTION (circle the right answer)

- 1) Do you often feel tired during the day?
0: no 1: yes
- 2) Are you restless at night?
0: no 1: yes
- 3) Do you snore?
0: no snoring in any given position
1: intermittent and discrete snoring only when lying on the back
2: constant and clear snoring only when lying on the back
3: constant or loud snoring in all positions
4: socially unacceptable snoring (sleeping together is impossible, disturbing for surroundings)
- 4) Are you sleepy during the day?
0: no sleepiness
1: mild sleepiness present
2: sleepiness disturbs the daily activities (driving a car, professional,...)
3: daily activities impossible

Appendix 1 continues on the following page

APPENDICES (*continued*)

- 5) Do you sometimes fall asleep during the day?
 0: never
 1: < 1× a week
 2: > 1× a week
 3: daily
- 6) Do you suffer from morning headaches?
 0: never
 1: < 1× a week
 2: > 1× a week
 3: daily
- 7) Do you suffer from loss of memory?
 0: no 1: yes
- 8) Do you wake up at night after falling asleep?
 0: no
 1: sometimes When? _____
- 9) Do you feel fresh and alert in the morning after awaking?
 0: no 1: mostly
- 10) Do you feel more tired in the morning as opposed to when you go to sleep?
 0: no 1: mostly
- 11) How deep is your sleep; deep or superficial (superficial in case you awaken easily)?
 0: deep 1: superficial
- 12) Has your partner noticed pauses in your breathing while you are asleep?
 0: no 1: yes
- If yes, specify: 0 when lying on the back
 0 in all positions
- 13) Do you feel anxious at night or do you have breathing problems?
 0: never
 1: < 1× a week
 2: > 1× a week
 3: daily
- 14) Do you sometimes feel unpleasant pins and needles in your legs, which make you move your legs?
 0: no 1: yes
- 15) Does your bedpartner notice any uncontrolled leg movements in your sleep? (e.g. kicking with your legs)
 0: no 1: yes

Appendix 1 continues on the following page

APPENDICES (continued)

16) Are you satisfied with your sleep?

0: no 1: yes

If not, what is the main problem?

0 difficulty falling asleep

0 difficulty sleeping through the night

0 waking up too early

17) When did your complaints about snoring start?_____

18) Have you gained weight the last few years? Y / N

_____kg / _____years

19) Have you previously sought help for your snoring problem?

0: no 1: yes

If yes, which help or which treatments?_____

Have these treatments helped you?_____

20) Use of alcohol:

Number of glasses beer and/or wine a week?

Before :_____

Now :_____

Do you use any alcohol before bedtime?

0: no 1: yes

21) Use of coffee:_____cups of coffee a day (number)

22) Smoking habits:

- how much do you smoke a day?_____

- for how many years?_____years

If you have stopped smoking:

- Number of years stopped:_____

- Started smoking at the age of_____

- Stopped smoking at the age of_____

- How much did you smoke a day?_____

Appendix 1 continues on the following page

APPENDICES (continued)

23) Illnesses and operations? (circle the right answer or fill in)

Throat-Nose-Ear:

- extraction of polyps: Y / N
- extraction of tonsils: Y / N
- runny nose: Y / N
- blocked nose: Y / N
- nasal septum deviation: Y / N
- allergies: Y / N

Which: _____

Heart:

- heart rhythm disorder: Y / N
- myocardial infarction: Y / N
- high blood pressure: Y / N

When: _____

Lungs:

- chronic bronchitis: Y / N
- asthma: Y / N

Nervosity, depression, overworked? (circle)

Do you have back problems (or in the past)? Y / N

Other illnesses? _____

Which operations have you got? _____

24) Have you ever got a serious traffic accident? Y / N

How many times have you been involved in a traffic accident? _____ times

How many times in the last year have you been able to just avoid an accident? _____ times

25) Medication?

Do you regularly use:

- nose sprays Y / N
- puffs for the airways Y / N
- blood pressure medication Y / N
- sleeping pills Y / N

Write down every medication you are taking at the moment:

- _____
- _____
- _____
- _____

Appendix 1 continues on the following page

APPENDICES (continued)

26) Height:_____cm Weight:_____kg

 Neck size (or size of your shirt):_____cm

 Blood pressure:_____/_____mm Hg

27) Libido (sexual drive)

 0: normal 1: less than normal

28) How often do you have to go to the toilet at night?_____times.

29) Concentration problems?

 0: no 1: yes

30) Do you suffer from heartburn or a burning sensation after a meal? During the day or at night? (circle)

 0: never

 1: < 1× a week

 2: > 1× a week

 3: daily

31) What time do you normally go to bed?_____h_____

 What time do you normally get up?_____h_____

32) For the ladies:

 0: I am before menopause

 1: I am in menopause (“hot flushes,”...)

 2: I am past menopause

33) Remarks of spouse:

34) Comments, miscellaneous:

APPENDICES *(continued)*

Appendix 2: Routine dental questionnaire

1. How do you score your health in general?
Excellent - very good - good - moderate - bad
2. How do you score your oral health in general?
Excellent - very good - good - moderate - bad
3. Have you had facial pain in the past month (meaning: pain in the face, the temporal region, the jaws, frontal to or in the ear)?
Yes - No
>>> ***If not, go to question 14*** <<<
4. a. How many years ago did you experience facial pain for the first time?
1 - 2 - 3 - 4-5 - 5-7 - 8-10 - >10

b. How many months ago did you experience facial pain for the first time?
1 - 2 - 3 - 4-5 - 5-7 - 8-10 - >10
5. Is the facial pain continuously or intermittently present, or was it a one-time occurrence?
Continuously - intermittently - one-time occurrence
6. Did you ever visit a doctor, a dentist, a chiropractor or any other health professional for the facial pain?
- No
- Yes, in the past 6 months
- Yes, more than 6 months ago
7. How do you score the facial pain that you feel at this moment, on a scale from 0 to 10, with 0 meaning 'no pain' and 10 meaning 'the worst possible pain'?
8. How do you score the intensity of the worst facial pain you experienced in the past 6 months, on a scale from 0 to 10, with 0 meaning 'no pain' and 10 meaning 'the worst possible pain'?
9. How do you score the average intensity of the facial pain you experienced in the past 6 months, on a scale from 0 to 10, with 0 meaning 'no pain' and 10 meaning 'the worst possible pain'? (meaning the usual pain you experienced on moments of pain)
10. What is the approximate number of days in the past 6 months that you could not carry out your normal activities (school, work, housework) due to the facial pain?
11. Score on a scale of 0 to 10 the extent to which the facial pain influenced your daily activities in the past 6 months, with 0 meaning 'no hindrance' and 10 meaning 'not capable of any activity'.
12. Score on a scale of 0 to 10 the extent to which the facial pain influenced your participation in social, recreational and familial activities with 0 meaning 'no hindrance' and 10 meaning 'not capable of any activity'.
13. Score on a scale of 0 to 10 the extent to which the facial pain influenced your work (incl. housework) with 0 meaning 'no hindrance' and 10 meaning 'not capable of any activity'.

Appendix 2 continues on the following page

APPENDICES (continued)

14. a. Have your temporal joints ever been locked or fixed, causing your mouth not to fully open or close?
Yes - No
>>> **If not, go to question 15 a** <<<
- b. Was this limitation of movement to such an extent that you had difficulties eating?
Yes - No
15. a. Do the joints make a clicking or popping sound when opening or closing the mouth or during chewing?
Yes - No
- b. Do the joints make a scraping or grinding sound when opening or closing the mouth or by chewing?
Yes - No
- c. Have you ever been told or are you aware of the fact that you grind your teeth or clench the jaws when you are asleep?
Yes - No
- d. Do you grind the teeth or clench the jaws during the day?
Yes - No
- e. Do you have painful or stiff jaw muscles in the morning upon awakening?
Yes - No
- f. Do you hear noises or ringing in the ears?
Yes - No
- g. Does your bite feel uncomfortable or different than how it normally feels?
Yes - No
16. a. Do you suffer from rheumatoid arthritis, lupus erythematoses or another systemic joint disease?
Yes - No
- b. Does any family member suffer from one of the former diseases?
Yes - No
- c. Have you had or do you have swollen or painful joints, other than the temporal joints?
Yes - No
>>> **If not, go to question 17 a** <<<
- d. Was it or is it a persistent pain, during at least one year?
Yes - No
17. a. Have you recently had an injury in the face?
Yes - No
>>> **If not, go to question 18** <<<
- b. Was the facial pain already present prior to the injury?
Yes - No
18. Have you suffered from headache or migraine during the past 6 months?
Yes - No

Appendix 2 continues on the following page

APPENDICES (*continued*)

19. a. Are you hindered or impeded during chewing by the current problem with the joints?
Yes - No
- b. Are you hindered or impeded during drinking by the current problem with the joints?
Yes - No
- c. Are you hindered or impeded during physical exercise by the current problem with the joints?
Yes - No
- d. Are you hindered or impeded upon eating of hard food by the current problem with the joints?
Yes - No
- e. Are you hindered or impeded upon eating of soft food by the current problem with the joints?
Yes - No
- f. Are you hindered or impeded upon smiling or laughing by the current problem with the joints?
Yes - No
- g. Are you hindered or impeded during sexual activities by the current problem with the joints?
Yes - No
- h. Are you hindered or impeded upon brushing your teeth or cleansing the face by the current problem with the joints?
Yes - No
- i. Are you hindered or impeded upon swallowing by the current problem with the joints?
Yes - No
- j. Are you hindered or impeded upon talking by the current problem with the joints?
Yes - No
- k. Are you hindered or impeded in your usual facial expression by the current problem with the joints?
Yes - No
20. a. To what extent have you been hindered by headache in the past week, including today?
Not at all - slightly - moderately - quite a bit - extremely
- b. To what extent have you been hindered by chest pain in the past week, including today?
Not at all - slightly - moderately - quite a bit - extremely
- c. To what extent have you been hindered by low back pain in the past week, including today?
Not at all - slightly - moderately - quite a bit - extremely
- d. To what extent have you been hindered by sore muscles in the past week, including today?
Not at all - slightly - moderately - quite a bit - extremely
- e. To what extent have you been hindered by difficulties in breathing in the past week, including today?
Not at all - slightly - moderately - quite a bit - extremely
- f. To what extent have you been hindered by dizziness in the past week, including today?
Not at all - slightly - moderately - quite a bit - extremely

Appendix 2 continues on the following page

APPENDICES (*continued*)

- g. To what extent have you been hindered by nausea or stomach problems in the past week, including today?
Not at all - slightly - moderately - quite a bit - extremely
- h. To what extent have you been hindered by a hot-cold feeling in the past week, including today?
Not at all - slightly - moderately - quite a bit - extremely
- i. To what extent have you been hindered by a numbness or tingling anywhere in your body in the past week, including today?
Not at all - slightly - moderately - quite a bit - extremely
- j. To what extent have you been hindered by the sensation of an obstruction in the throat in the past week, including today?
Not at all - slightly - moderately - quite a bit - extremely
- k. To what extent have you been hindered by a sense of physical weakness in the past week, including today?
Not at all - slightly - moderately - quite a bit - extremely
- l. To what extent have you been hindered by a heavy feeling in the arms and legs in the past week, including today?
Not at all - slightly - moderately - quite a bit - extremely
- m. To what extent have you been hindered by difficulties falling asleep in the past week, including today?
Not at all - slightly - moderately - quite a bit - extremely
- n. To what extent have you been hindered by waking up early in the past week, including today?
Not at all - slightly - moderately - quite a bit - extremely
- o. To what extent have you been hindered by a restless or disturbed sleep in the past week, including today?
Not at all - slightly - moderately - quite a bit - extremely
- p. To what extent have you been hindered by unpleasant thoughts or not getting rid of certain thoughts in the past week, including today?
Not at all - slightly - moderately - quite a bit - extremely
- q. To what extent have you been hindered by a loss of libido or not enjoying sexual activities in the past week, including today?
Not at all - slightly - moderately - quite a bit - extremely
- r. To what extent have you been hindered by a lack of energy in the past week in the past week, including today?
Not at all - slightly - moderately - quite a bit - extremely
- s. To what extent have you been hindered by suicidal thoughts in the past week, including today?
Not at all - slightly - moderately - quite a bit - extremely
- t. To what extent have you been hindered by a poor appetite in the past week, including today?
Not at all - slightly - moderately - quite a bit - extremely
- u. To what extent have you been hindered by weeping easily in the past week, including today?
Not at all - slightly - moderately - quite a bit - extremely
- v. To what extent have you been hindered by feeling entangled or trapped in the past week, including today?
Not at all - slightly - moderately - quite a bit - extremely

Appendix 2 continues on the following page

APPENDICES (*continued*)

- w. To what extent have you been hindered by blaming yourself all sorts of things in the past week, including today?
Not at all - slightly - moderately - quite a bit - extremely
- x. To what extent have you been hindered by feeling lonely in the past week, including today?
Not at all - slightly - moderately - quite a bit - extremely
- y. To what extent have you been hindered by being upset in the past week, including today?
Not at all - slightly - moderately - quite a bit - extremely
- z. To what extent have you been hindered by worrying too much about things in the past week, including today?
Not at all - slightly - moderately - quite a bit - extremely
- aa. To what extent have you been hindered by not being interested in anything in the past week, including today?
Not at all - slightly - moderately - quite a bit - extremely
- bb. To what extent have you been hindered by a feeling of emptiness in the past week, including today?
Not at all - slightly - moderately - quite a bit - extremely
- cc. To what extent have you been hindered by feeling desperate about the future in the past week, including today?
Not at all - slightly - moderately - quite a bit - extremely
- dd. To what extent have you been hindered by thinking about death or dying in the past week, including today?
Not at all - slightly - moderately - quite a bit - extremely
- ee. To what extent have you been hindered by feeling worthless in the past week, including today?
Not at all - slightly - moderately - quite a bit - extremely
21. How well do you take care of your general health?
Excellent - very good - good - moderate - bad
22. How well do you take care of your oral health?
Excellent - very good - good - moderate - bad