Oral Appliance Sleep Journal

Patient's Name:	Date of Birth:
Date:	Date:
Bathroom Visits:	Bathroom Visits:
Bed Time:	Bed Time:
Wake Up Time:	Wake Up Time:
Any discomfort with teeth?	Any discomfort with teeth?
How did you sleep? (Brief Description)	How did you sleep? (Brief Description)
Date:	Date:
Bathroom Visits:	Bathroom Visits:
Bed Time:	Bed Time:
Wake Up Time:	Wake Up Time:
Any discomfort with teeth?	Any discomfort with teeth?
How did you sleep? (Brief Description)	How did you sleep? (Brief Description)
Date:	Date:
Bathroom Visits:	Bathroom Visits:
Bed Time:	Bed Time:
Wake Up Time:	Wake Up Time:
Any discomfort with teeth?	Any discomfort with teeth?
How did you sleep? (Brief Description)	How did you sleep? (Brief Description)