Oral Appliance Sleep Journal

Patient's Name: _____________________________________ Date of Birth:________________

Date: ________________ Bathroom Visits: _______ Bed Time: ____________ Wake Up Time: ________ Any discomfort with teeth? ____________________ How did you sleep? (Brief Description)	Date: ________________ Bathroom Visits: _______ Bed Time: ____________ Wake Up Time: ________ Any discomfort with teeth? ____________________ How did you sleep? (Brief Description)
Date: ________________ Bathroom Visits: _______ Bed Time: ____________ Wake Up Time: ________ Any discomfort with teeth? ____________________ How did you sleep? (Brief Description)	Date: ________________ Bathroom Visits: _______ Bed Time: ____________ Wake Up Time: ________ Any discomfort with teeth? ____________________ How did you sleep? (Brief Description)
Date: ________________ Bathroom Visits: _______ Bed Time: ____________ Wake Up Time: ________ Any discomfort with teeth? ____________________ How did you sleep? (Brief Description)	Date: ________________ Bathroom Visits: _______ Bed Time: ____________ Wake Up Time: ________ Any discomfort with teeth? ____________________ How did you sleep? (Brief Description)