ALAMO MAXILLOFACIAL
SURGICAL ASSOCIATES, PA

SLEEP APNEA EVALUATION

INTRODUCTION

As you are probably well aware, the definitive evaluation of sleep apnea can be a lengthy and involved process. Overall, your evaluation and treatment may involve a variety of specialists. As surgeons, it is our goal to assess your condition, give feedback to the other doctors involved in your care, and provide treatment when indicated. In order to accomplish this, we need to collect a great deal of information about your history and your current condition. Your evaluation may include some or all of the following studies; a detailed questionnaire, photographs, a series of x-rays, dental models and a detailed physical examination.

As you complete the questionnaire, please do not be offended or embarrassed by some of the questions; they are important in your evaluation. You can be assured that the strictest confidentiality will be exercised. Next you may notice that some of the questions may be too specific, or you may not know the answers. That is okay. Just indicate this next to those questions.

Your entire evaluation will take a significant amount of time. Please be aware that the collection of all the necessary information can often take up to a few hours total. If any part of your evaluation seems confusing to you, or if you have questions, please ask us for assistance. We are here to help you.

SLEEP APNEA QUESTIONNAIRE

1. Who is your primary care physician (the doctor responsible for the majority of your medical care?) _____

2. Who is your dentist? _____

3. What caused you to seek evaluation for sleep apnea? _____

4. Who did you first see for evaluation? _____

5. Please indicate "Yes" or "No" to the following questions:

	YES	NO
Do you snore?	_____	_____
Do you have frequent sore throats?	_____	_____
Are you a smoker?	_____	_____
Have you ever been told that you stop breathing for periods of time while sleeping?	_____	_____
Do you experience daytime sleepiness?	_____	_____
Have you ever fallen asleep at work or during social activities?	_____	_____
Do you feel your performance at work is not what it could be, if you had increased alertness?	_____	_____
Do you often feel as if your memory and/or judgment is affected?	_____	_____
Have you noticed a decrease in sexual desire?	_____	_____
Do you feel you are overweight?	_____	_____
If so, how long have you been overweight? 1 yr_____ 2 yr_____ 3yr_____	_____	_____
Do you often feel depressed?	_____	_____

If so, for how long? _____

With what medication(s) _____

Have you ever been diagnosed with any of the following medical conditions?	YES	NO
Arrhythmia (Heart Irregularity)	_____	_____
Hypertension (High Blood Pressure)	_____	_____
Pulmonary Hypertension	_____	_____
Polycythemia	_____	_____
Asthma	_____	_____
Emphysema	_____	_____
Neurological Disorder	_____	_____
Thyroid Disorder	_____	_____

6. Have you ever been treated for sleep apnea? _____ _____

If so, which of the following have you tried?

Diet _____
Medications _____
Mouthpiece _____
Oxygen _____
CPAP _____

7. Have you ever had any operations for sleep apnea? _____ _____

If so, which of the following have you had?	YES	NO	Don't Know
Nasal Surgery	_____	_____	_____
Tonsillectomy/Adenoidectomy	_____	_____	_____
Palatoplasty ("UPPP")	_____	_____	_____
Glossoplasty (tongue reduction)	_____	_____	_____
Osteotomy (movement of the jaws)	_____	_____	_____

Name of surgeon(s) _____
_____

8. Would you consider having surgery if you felt it would improve your condition? _____ _____

9. Prior to being referred to us for evaluation, what specialists have you seen for evaluation and/or treatment?

	Name	Estimated Dates of Treatment	
Neurologist	_____	_____	_____
Pulmonologist	_____	_____	_____
Internist	_____	_____	_____
Psychologist	_____	_____	_____
Other	_____	_____	_____

		YES	NO
10.	Have you been to a "Sleep Lab" for evaluation?	_____	_____

Date(s) _____

Name of Sleep Lab _____

If you have been to a sleep lab, do you know the results? If so, please give a brief summary in your own words?

_____
_____
_____
_____

Do you remember being given a score called an "RDI"? IF so, what was your "RDI"? _____

THE EPWORTH SLEEPINESS SCALE

Name _____

Today's Date _____ Your Age (yrs)_____

Your sex (male = M; female = F)_____

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired? This refers to your usual way of life in recent times. Even if you have not done some of these things recently try to work out how they would have affected you. Use the following scale to choose the most appropriate number for each situation:

0 = would ***never*** doze
1 = ***slight*** chance of dozing
2 = ***moderate*** chance of dozing
3 = ***high*** chance of dozing

SITUATION	**CHANCE OF DOZING**
Sitting and reading	_____
Watching TV	_____
Sitting, inactive in a public place (e.g. a theater or a meeting)	_____
As a passenger in a car for an hour without a break	_____
Lying down to rest in the afternoon when circumstances permit	_____
Sitting and talking to someone	_____
Sitting quietly after a lunch without alcohol	_____
In a car, while stopped for a few minutes in traffic	_____