To use this form you must have Acrobat Reader 5 or greater installed.
Click here to download Acrobat Reader 6.

- To enter in text, click in the area you wish to type in and begin typing.

- To check off choices on the form, click on the area you'd like to check.

- To send the completed form to our office, click “Submit” at the bottom of the last page.

- Feel free to print out a copy of the form before you send it to retain for your records.

If you experience difficulty submitting this form you can also print the blank form, fill out with black pen and bring the form to the office at the time of your appointment. If you do not have a printer you can fill out the form at the office at the time of your appointment.

Please fill out the form as completely as possible, and if you have any questions about this form please contact your doctor.

For your protection:
This form is hosted on a secure server and can only be viewed by our office. Please feel confident in filling out this form, as all of your information will be kept safe at every step of the process. *Your form will not be sent via email at any time to ensure the complete security of your information.*

NORTHERN TEXAS FACIAL & ORAL SURGERY
The Dental Implant Center

David K. Hunter, DDS
Dean B. Spingola, DMD, MD
Craig E. Buchmann, DDS
Diplomates of the American Board of Oral & Maxillofacial Surgery

Obstructive Sleep Apnea Syndrome Evaluation

Name: _____ Birth Date: _____

What is your height? _____ft _____inches

Present body weight? _____lbs

Weight gained in last 12 months _____lbs

Do you have, or have you ever had any of the following:

Snoring that disturbs you or your partner	Y☐	N☐
Snoring every night	Y☐	N☐
Breathing pauses	Y☐	N☐
Waking up gasping	Y☐	N☐
Restless sleep	Y☐	N☐

How many hours sleep do you get on a typical night?_____

How many hours do you typically nap during the day?_____

How many times do you rise to use the toilet on a typical night?_____

While awake, do you have or have you ever had:

Daytime sleepiness	Y☐	N☐
Daytime tiredness	Y☐	N☐
Problems falling asleep at work	Y☐	N☐
Headaches upon awakening	Y☐	N☐

What are your mealtimes for:

Breakfast?_____
Lunch?_____
Dinner?_____

Do you snack before bedtime? Y☐ N☐

Do you use

Alcohol? How much? _____
Nicotine? How much?_____
Prescription medications? (Specify)
_____
Over the counter (nonprescription) medications? (Specify)
_____

Stress

Do you grind your teeth at night	Y☐	N☐
Are you concerned about family/work problems?	Y☐	N☐
Are you depressed?	Y☐	N☐
Are you tense, wide-awake when trying to go to sleep?	Y☐	N☐
Do you have financial problems?	Y☐	N☐

Have you had treatment or been diagnosed for:

Snoring	Y☐	N☐
Obstructive Sleep Apnea	Y☐	N☐
Enlarged tonsils	Y☐	N☐
Enlarged adenoids	Y☐	N☐
Nasal obstruction	Y☐	N☐
Sinus disease or problems	Y☐	N☐
Tracheotomy	Y☐	N☐
Sleep disorders, or a sleep study	Y☐	N☐
Allergies not already disclosed	Y☐	N☐

Patient Signature & Date _____

Signatures to be completed during office visit.

The Epworth Sleepiness Scale

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 affect you.

Situation / Activity	Chance of Dozing			
	0 Never	1 Slight	2 Moderate	3 High
Sitting and reading				
Watching TV				
Sitting, inactive in public place (e.g. theater or meeting)				
As a passenger in a car for an hour without break				
Lying down to rest in afternoon when circumstances permit				
Sitting and talking to someone				
Sitting quietly after lunch without alcohol				
In car, while stopped for a few minutes in traffic				
Total Score				

Behavior During Sleep

Use the following scale to choose the most appropriate number for each situation. Indicate whether, during your usual sleep, you have noticed or been told that you have the indicated symptoms:

Symptom	0 Never	1 Less than once a week	2 Once to about half the nights per week	3 Half the nights to almost always	4 Almost always or every night	? Don't know or haven't been told
Snore loudly						
Stop breathing						
Choke, struggle for breath						
Toss and turn frequently						
Wake up with headache						
Total Score						

Submit Form