CPAP/BiPAP FOLLOW-UP QUESTIONNAIRE

Please place an "X" in the column where appropriate, or NA (not applicable).

BENEFITS of CPAP / BiPAP compared to no treatment:	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
1. I wake up less to use the bathroom.					
2. I am more physically active during the day.					
3. I have more energy.					
4. I'm in a better mood (less anxious, sad, irritable).					
5. I no longer become sleepy while sitting or driving.					
6. I use less caffeine/fewer stimulants.					
7. My bed partner sleeps better.					
8. I cope better with stress.					
9. I can concentrate and think more clearly.					
10. I sleep more/less (circle one).					
11. I dream more/less (circle one).					
12. My shortness of breath is less bothersome.					
13. I have stopped taking / reduced dose of medications					

Please list these medications: _____

14. Other benefits (reduced appetite, improved sexual interest/function, return to work, etc.) _____

_____

PROBLEMS specifically associated with CPAP / BiPAP:	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
15. It leaks air or water (circle which).					
16. It irritates my eyes, nose, or face (circle which).					
17. I still snore when using it.					
18. It is noisy.					
19. It makes me feel claustrophobic (closed in).					
20. Air sometimes leaks past my lips.					
21. I wake up with my mouth dry.					
22. It makes my nose stuffy.					
23. It causes nosebleeds.					
24. It is difficult to use.					
25. It gives me headaches.					
26. It reduces intimacy with my bed partner.					
27. It is too expensive.					
28. It gives me stomach and/or intestinal gas.					
29. It gives me chest pains.					
30. It gives me not enough / too much air (circle which).					

31. Other problems (chin strap discomfort, drooling, ramp problems, etc.)_____

_____

32. I wake up to use the **bathroom** at night: yes no number of times: ____
33. I use CPAP/BiPAP ____ nights per week.
34. I sleep ____ hours per night. I sleep with CPAP/BiPAP ____ hours per night. I take ____ naps per week.
35. I use a **chin strap** (circle): nightly sometimes never
36. I use a heated / unheated (circle) **humidifier** in the CPAP system (circle): nightly sometimes never
    Water left in humidifier in morning if full at bedtime (circle): empty ¼ full ½ full ¾ full full
37. I get new headgear every ____ months. I clean the humidifier every ____ days. I get new filters every ____ .
38. Satisfaction with medical equipment supplier (circle): excellent satisfactory needs improvement

(OVER)

Sleep Consultants, Inc.
1521 Cooper Street ♦ Fort Worth, Texas 76104 ♦ (817) 332-7433 ♦ Fax (817) 336-2159

Comprehensive Care of Sleep Disorders
Diagnosis, Treatment, Follow-up, Education

Patient care and business functions at 1521 Cooper Street
Sleep Laboratory - 909 8th Avenue, Fort Worth, TX 76104
Email: information@sleepconsultants.com
Website: http://www.sleepconsultants.com

EPWORTH SLEEPINESS SCALE

Patient's Name: _____ Account#: _____ Date: _____

Directions:
As of today, how likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired? Even if you have not done some of these things recently, try to work out how they would have affected you. Please use the following scale to choose the most appropriate number for each situation:

To be completed *by the patient* using the following directions:

Rating scale for chance of dozing: 0 = NEVER, 1 = SLIGHT, 2 = MODERATE, 3 = HIGH

Rated Chance of Dozing	*Situation*
_____	Sitting and reading
_____	Watching TV
_____	Sitting inactive in a public place (e.g. a theater or 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
_____	Total score

To be completed *by the staff*:

Mask/ADAM Circuit:
Manufacturer: _____ Type: _____ Size: _____

Machine:
Manufacturer: _____ Model:_____

Type of machine: ☐ CPAP ☐ BiPAP ☐ BiPAP S ☐ BiPAP T

Pressure ordered:_____ Pressure measured:_____

Problems?: _____
_____

Oral Appliance:_____

Staff Initials:_____

(OVER)