Sleep Medicine Services of Western Massachusetts

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CPAP/BPAP/ASV Treatment Questionnaire

Name: **Date:**

Please tell us about your situation since your last visit here. Circle as appropriate.

1. Do you use:
   - CPAP
   - BiPAP
   - ASV
   - Other/unknown

2. What type of interface do you have?
   - Nasal mask
   - Full face mask
   - Nasal pillows

3. What company provides your supplies?
   - Sleep Medicine Services (this office)
   - Lincare
   - Baystate Home Infusion and Respiratory Services
   - Sleep Management Solutions
   - Apria
   - J&L
   - Life Supply

4. Any problems with your treatment?
   - Skin irritation (nose, cheeks, other)
   - Leakage
   - Interface too tight
   - Loose or uncomfortable headgear (straps)
   - Condensation in tubing
   - Machine too noisy
   - Pressure seems excessive
   - Pressure seems too weak
   - Can't exhale easily
   - Air too cold/ Air too dry

5. How often are you using your machine?
   - Every night or almost every night
   - Several nights per week
   - A few nights per week
   - Occasionally
   - Not at all recently

6. What disturbs your sleep regularly?
   - Noise in the home
   - Excessive light
   - Too hot or cold
   - More than one trip to the toilet
   - Sweating
   - Pain
   - Restless legs
   - Generalized restlessness
   - Bed partner
   - Children
   - Pets
   - Dreaming
   - Stress during the day

7. How do you feel during the day?
   - Alert and energetic generally
   - Often sleepy
   - More fatigued than sleepy
   - Unable to function

Continued on reverse side.

8. In the following situations, what is the chance that you would doze off? (Use the 0-3 scale given below.)

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	
TOTAL SCORE	

0 = no chance of dozing
1 = slight chance of dozing
2 = moderate chance of dozing
3 = high chance of dozing

9. Do you feel adequately alert to drive safely?
   - Yes
   - Uncertain
   - No

10. What is the status of your weight?
   - Stable
   - Increasing
   - Decreasing

11. How much exercise do you get?
   - Just routine activities
   - Walking a mile or more at least 3X per week
   - Jogging (or similar) 30 min at least 3X per week
   - More than the above

12. How much caffeine do you use?
   - None
   - 1-2 beverages daily on average
   - 3-4 beverages daily on average
   - 5 or more beverages daily

13. How much alcohol do you use?
   - None
   - A few drinks per week
   - 1-2 drinks daily on average
   - ≥3 drinks daily on average

14. Any recent symptoms or medical problems?
   - Heart attack
   - Heart rhythm problem
   - Stroke or TIA
   - Hospitalization
   - Motor vehicle accident
   - Injury
   - Frequent headache
   - Shortness of breath
   - Chest pain
   - Nasal congestion
   - Cough
   - Other: _____

15. Has there been any change in your medications?
   - No
   - Yes: _____
     _____