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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: _____