SLEEP HEALTH CLINIC

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CPAP/BIPAP Questionnaire

Patient name: _____

Date of birth: _____ Age:_____

1) Are you currently on treatment for Sleep Apnea?

▫ YES ▫ NO

2) Do you use any of the following?

▫ CPAP ▫ BiPAP ▫ ASV ▫ Oxygen ▫ Oral Appliance

3) How often do you use your CPAP?

▫ Daily ▫ Other _____

4) What type of mask do you use?

▫ Full Face mask (nose and mouth) ▫ Nasal Mask ▫ Nasal Pillows mask

5) Do you use any of the following?

▫ Humidifier ▫ Chin Strap ▫ Heated tubing

6) Do you have any of the following issues when you use CPAP?

Mask leak / fit issues	▫ Yes	▫ No	▫ Occasionally
Pressure intolerance	▫ Yes	▫ No	▫ Occasionally
Dry Mouth	▫ Yes	▫ No	▫ Occasionally
Nasal Congestion	▫ Yes	▫ No	▫ Occasionally

7) Do you have any of the following symptoms despite using CPAP?

Snoring	▫ Yes	▫ No	▫ Occasionally
Pauses in breathing (apneas)	▫ Yes	▫ No	▫ Occasionally
Daytime Sleepiness	▫ Yes	▫ No	▫ Occasionally

8) Have you ever had any motor vehicle accidents from falling asleep while driving?

▫ YES ▫ NO

9) Have you noticed an improvement in the quality of your sleep?

□ YES □ NO

Epworth Sleepiness Scale

Grade your tendency to fall asleep during the following situations based on how you feel right now.

0 = Never 1 = Slight chance 2 = Moderate chance 3 = High chance

ACTIVITY	0	1	2	3
Sitting and reading	□	□	□	□
Watching TV	□	□	□	□
Sitting inactive in a public place	□	□	□	□
As a passenger in a car for 30 minutes without a break	□	□	□	□
Lying down to rest in the afternoon	□	□	□	□
Sitting and talking to someone	□	□	□	□
Sitting quietly after lunch	□	□	□	□
In a car while stopping for a few minutes	□	□	□	□

TOTAL: _____