Leading Edge Testing – Patient Centered Care

Initial Sleep Questionnaire: CPAP/BIPAP
Dr DellaBadia Sleep Clinic

1-866-499-1588

Name: _____ Appointment Date_____

Date of Birth_____ Age _____ Referring Physician_____

Main Sleep Complaint: _____

How long has this been going on? _____

Section A. CPAP/ BIPAP Questions

(Circle OR Fill in all that apply)

1. **How long have you been using a CPAP/BIPAP machine?** (_____ weeks) OR (_____ months) OR (____ years)
2. **How often do you use the CPAP / BIPAP?** Never / ____ times a week / Every night
3. **How many hours do you use the CPAP / BIPAP each night?** _____ hours
4. **On the average, how many hours do you sleep every night? _____** hours
5. **What pressure is the CPAP / BIPAP set on?** _____ cm H2O
6. **How does the CPAP / BIPAP pressure feel?** Too high / Too low / comfortable / Ok
7. **What type of mask do you use?** Nasal / Nasal-Oral / Nasal Pillows / Full Face / Cloth mask
8. **Does your mask leak?** Not at all / Rarely / Sometimes / Frequently / Every night
   - **a. It leaks….** Spontaneously / When I turn / When the pressure goes up / Other _____
9. **Does the CPAP/ BIPAP cause dry mouth?** Never / Rarely / Sometimes / Frequently /Always
10. **Do you put water in the CPAP water canister?** Yes / No **Setting level: _____**
11. **Do you snore when using CPAP/BIPAP?** Never / Rarely / Sometimes / Frequently / Always / Does not know
12. **Do you awaken from sleep gasping or choking when using the CPAP/BIPAP?**
    Never / Rarely / Sometimes / Frequently / Every night
13. **Has anyone noticed that you stop breathing when you are asleep while using the CPAP/BIPAP?** Yes / No
14. **If you take your mask off during the night, why…?** Mask is uncomfortable / Mask leaks / Pressure is too high / Feel claustrophobic / Feel like I'm smothering / Can't breathe / Dries out my nose and mouth / I wake up and it's already off / Other_____
15. **How has CPAP / BIPAP helped improved the quality of your sleep?**
    Much better / better / improved / only slightly better / unchanged
16. **How do you feel upon awakening in the morning when using CPAP/BIPAP?**
    Hard to get out of bed / sleepy / tired / groggy / rested / refreshed

Section B. Sleep Review

(Circle when choices are provided)

17. What average time do you go to bed during the week? _____

18. What average time do you wake up to start the day? _____

19. How long does it take to fall asleep? _____mins OR _____ hours

20. Do you have trouble falling asleep? Never / Rarely / Sometimes / Frequently / Always

21. Once asleep, how many times do you wake up during the night? _____ times

22. Why do you wake up? Bathroom / Unsure / Light sleeper / Thirst / Noise / CPAP/BIPAP pressure / Mask leaks / Leg discomfort / Pain. Other _____

23. After awaking at night, how long does it take to fall back asleep? _____ mins OR _____ hours

24. Do you feel sleepy during the day when using the CPAP? Never / Rarely / Sometimes / Frequently / Every day

25. Do you fall asleep during the day, when….
Inactive / Watching TV / Eating / Standing / Talking / Working / Driving / None

26. Do you take naps during the day since using CPAP? Never / Rarely / Sometimes / Frequently / Every day

a. How long do the naps last? (_____ mins) OR (_____ hours)

b. Do you use CPAP during the naps? Never / Rarely / Sometimes / Frequently / Every day

Section C. Medications

1. Do you have any medication allergies? No/ Yes, list:_____

2. List any medications used for sleep:_____

3. List current medications:

_____
_____
_____
_____
_____
_____
_____

Section D. Review of Systems

[CIRCLE ALL THAT APPLY FOR THE LAST 3 MONTHS]

1. Constitutional Symptoms?
Fever
Chills
Systemic Illness
Night Sweats
Recent Fatigue
Poor Appetite
Weight Gain
Weight Loss
of _____ lbs in _____ months
Other_____
_____

2. Eye Symptoms?
Diminished vision
Blurry vision
Double vision
Blind spots
Eye pain
Eye Infection
Itchy eyes
Other_____
_____

3. ENT Symptoms?
Nose bleed
Loss of Smell
Nasal Congestion
Sinus Congestion
Nasal Obstruction
Post Nasal Drip
Runny Nose
Sinus Infection
Dryness of Mouth
Difficulty swallowing
Dizziness
Ringing in the Ears
Hearing Difficulty
Hearing Loss
Hoarseness
Sore Throat
Other_____
_____

4. Cardiovascular Symptoms?
Fainting
Lightheadedness
Chest Pain
Ankle Swelling
Irregular heart beat
Heart racing
Other_____
_____

5. Respiratory Symptoms?
Cough
Productive Cough
Coughing up blood
Difficulty breathing
Wheezing
Shortness of breath at rest
Shortness of breath with exertion
Shortness of breath lying down
Rib Pain
Other_____
_____

6. Gastrointestinal Symptoms?
Bloating
Indigestion
Heartburn
Nausea
Vomiting
Abdominal Pain
Constipation
Diarrhea
Food Intolerance
Other_____
_____

7. Genitourinary Symptoms?
Difficultly Voiding
Urinary hesitancy
Urinary urgency
Incontinence
Pain with urination
Blood in urine
Urinating many times each night
Urinary tract Infection
Kidney Stones
Women-- Abnormal menstrual cycle
Ovarian Cysts
Men-- Prostate Problems
Other_____
_____

8. Musculoskeletal Symptoms?
Joint Nodules
Joint stiffness
Morning Stiffness
Joint Swelling
Neck Pain
Hip Pain
Back Pain
Decreased Range of Motion
General Weakness
Weakness on one side of the body
Other_____
_____

9. Neurological Symptoms?
Lack of coordination
Falling
Tremor
Dizziness
Episodic loss of consciousness
Seizures
Decreased memory
Numbness / Tingling:
Where?_____
Migraines
Headaches
Other_____
_____

10. Psychiatric Symptoms?
Anxiety
Delusions
Disorientation
Depression
Mood Swings
Hallucinations
Paranoia
Suicidal thoughts
Other_____
_____

Section E. Past Medical History

AIDS or HIV
Alcohol Abuse
Drug Abuse
Fibromyalgia
Anemia
Angina
Arthritis
Asthma
Benign Tumor:
Type- _____
Bleeding disorder
Bronchitis
Cancer:
Type- _____
Carpal Tunnel Syndrome
Congestive Heart Failure
COPD
Emphysema
Coronary Artery Disease
Crohn's Disease
Degenerative Disc Disease
Depression
Diabetes Insulin Dependent
Diabetes Non-Insulin Dependent
Disc Injury
Disc herniation
Dizziness
Fainting
Gall Bladder Disease
Gastric acid reflux
Gout
Headache
Heart Arrhythmia
Heart Attack
Heart Disease
Heart Murmur
Heart Palpitations
Hepatitis A B C
Hypertension
High Cholesterol
Hyperthyroidism
Hypothyroidism
Incontinence (bowel or bladder)
Kidney Disease
Liver Disease
Lupus
Migraines
Mitral Valve Prolapse
Multiple Sclerosis
Narcolepsy
Neuropathy
Obesity
Obstructive Sleep Apnea
Osteoporosis
Parkinson's Disease
Pneumonia
Restless Leg Syndrome
Schizophrenia
Seizure / Epilepsy
Sexual/ Menstrual Dysfunction
Sickle Cell Disease
Sinus Disease
Stomach Ulcer
Stroke
Syncope

Other: _____

Section F. Past Surgical History

Amputation: _____
Appendectomy
Bladder Surgery
Bowel Resection
Coronary Artery Bypass
Cardiac Catheterization
Cardiac valve repair
Pacemaker Implantation
Cataract surgery
Cholecystectomy
Gall Bladder Surgery
Gastric Band
Gastric Bypass
Hip Replacement (RT / LT)
Knee replacement (RT/LT)
Hysterectomy
Kidney Surgery
Nasal Surgery
Sinus Surgery
Tonsillectomy
Adenoidectomy
Uluveopalatopharyngeo-plasty

Other _____

Section G. Social History

1. Marital Status? Single / Married / Separated / Divorced / Widowed / Significant other

2. Have you ever smoked at least 100 cigarettes in your entire life? No/ Yes

3. Current smoking status: Every day smoker / Some day smoker / Former smoker / Never smoked

4. Do you use alcohol? No/ Yes How Much_____ How often_____ For How Long_____

5. Do you use illegal drugs? Never / In the past / Currently. What type_____

6. Your occupation? _____

7. Number of Children? _____

Section H. Family History

1. Does any family member have…? (If so, who?)
***sleep apnea* _____*narcolepsy*_____ *restless leg syndrome*_____**

2. List any major illnesses in the family:

Mother _____

Father _____

Siblings _____

Children _____