Leading Edge Testing – Patient Centered Care

Follow-Up Sleep Questionnaire: CPAP/BIPAP

Dr DellaBadia Sleep Clinic

1-866-499-1588

Name: ____ **Appointment Date**_______________________________

Date of Birth______________________ **Age** ________ **Referring Physician**_____________________________

Main Sleep Complaint : ____

Section A. CPAP/ BIPAP Questions

1. **How often do you use the CPAP / BIPAP?** Never / ____ times a week / Every night
2. **How many hours do you use the CPAP / BIPAP each night?** _______ hours
3. **On the average, how many hours do you sleep every night?** _______ hours
4. **What pressure is the CPAP / BIPAP set on?** _________ cm H2O
5. **How does the CPAP / BIPAP pressure feel?** Too high / Comfortable / Ok **/** Too low
6. **What type of mask do you use?** Nasal / Nasal-Oral / Nasal Pillows / Full Face / Cloth mask
7. **Does your mask leak?** Not at all / Rarely / Sometimes / Frequently / Every night
8. **Does CPAP/ BIPAP cause dry mouth?** Never / Rarely / Sometimes / Frequently /Always
9. **Do you put water in the CPAP water canister?** Yes / No **Setting level:** _______
10. **Do you snore when using CPAP/BIPAP?** Never / Rarely / Sometimes / Frequently / Always / Does not know
11. **Do you awaken from sleep gasping or choking when using the CPAP/BIPAP?**
    Never / Rarely / Sometimes / Frequently / Every night
12. **Has anyone noticed that you stop breathing when you are asleep while using the CPAP/BIPAP?** Yes / No / ??
13. **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____
14. **Once asleep, how many times do you wake up during the night?** ________ times
15. **Why do you wake up?** Bathroom / Unsure / Light sleeper / Thirst / Noise / CPAP/BIPAP pressure / Mask leaks /
    Leg discomfort / Pain. Other ____
16. **How has CPAP / BIPAP helped improve the quality of your sleep?**
    Much better / better / improved / only slightly better / unchanged
17. **How do you feel upon awakening in the morning when using CPAP/BIPAP?**
    Hard to get out of bed / sleepy / tired / groggy / rested / refreshed
18. **Do you feel sleepy during the day when using the CPAP?** Never / Rarely / Sometimes / Frequently / Every day
19. **Do you fall asleep during the day, when….**
    Inactive / Watching TV / Eating / Standing / Talking / Working / Driving / None
20. **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 B. Review of Systems

[CIRCLE ALL THAT APPLY FOR THE LAST 3 MONTHS]

1. Constitutional?
Fever
Chills
Systemic Illness
Night Sweats
Recent Fatigue
Poor Appetite
Weight Gain OR 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?
Nasal Obstruction
Nose bleed
Loss of Smell
Nasal Congestion
Sinus Congestion
Post Nasal Drip
Runny Nose
Sinus Infection
Dryness of Mouth
Difficulty swallowing
Hoarseness
Sore Throat
Dizziness
Ringing in the Ears
Hearing Difficulty
Hearing Loss
Other___________________

4. Cardiovascular?
Lightheadedness
Fainting
Chest Pain
Ankle Swelling
Heart racing
Irregular heart beat
Other___________________

5. Respiratory?
Cough
Productive Cough
Coughing up blood
Difficulty breathing
Wheezing
Shortness of breath-
at rest
with exertion
upon lying down
Rib Pain
Other___________________

6. Gastrointestinal?
Bloating
Indigestion
Heartburn
Nausea
Vomiting
Abdominal Pain
Constipation
Diarrhea
Food Intolerance
Other___________________

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

8. Musculoskeletal?
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. Neurologic?
Lack of coordination
Falling
Tremor
Dizziness
Loss of consciousness
Seizures
Decreased memory
Migraines
Headaches
Numbness / Tingling:
Where?___________
Other___________________

10. Psychiatric?
Anxiety
Irritable
Delusions
Disorientation
Depression
Mood Swings
Hallucinations
Paranoia
Suicidal thoughts
Other___________________

Section C. Medications

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

2. List any medications used for sleep:____

3. List current medications: ____

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____

____

____

Section D. Medical History

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

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

3. Any new medical/surgical problems since your last visit? No/ Yes If yes, ______________________________

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