CPAP Follow Up Questionnaire

Patient: _____ **DOB:** _____ **Date:** 2020

Sleep Schedule

Bed time _____ am/pm
Out of bed for the day _____ am/pm
Awakenings per night _____
I fall asleep within _____ mins

Check all improvements that apply since starting PAP:

- ☐ Sleepiness has improved
- ☐ Fatigue has improved
- ☐ Snoring resolved
- ☐ Apnea resolved
- ☐ Gasping/choking resolved
- ☐ Headaches decreased
- ☐ Memory better
- ☐ Focus/concentration improved
- ☐ Sleep is less restless
- ☐ Sleep quality has improved
- ☐ Less irritable
- ☐ Napping less frequently
- ☐ There has been no decline in these improvements since starting PAP
- ☐ There has been some decline in these improvements since my last visit

Sleeping medications or stimulants:

Frequency:

What type of mask are you currently using?
Pillows _____ Nasal Mask _____
Full Face _____ Chinstrap _____
How old is your cushion _____
What is your current CPAP/BIPAP setting? _____
How long have you been on CPAP therapy? _____
How old is your current PAP machine? _____
How old is your current headgear? _____

How many hours per night are you wearing your CPAP? _____
How many nights per week are you using your CPAP? _____

What is the name of your DME company? _____
How would you rate your DME? Poor Fair Good Excellent

Epworth Sleepiness Scale : USE KEY:

0 NEVER doze
1 SLIGHT chance of dozing
2 MODERATE chance of dozing
3 HIGH chance of dozing

Situation	Chance of Dozing
Sitting and reading	0 1 2 3
Watching television	0 1 2 3
Sitting, inactive in a public place (i.e. theatre or meeting)	0 1 2 3
As a passenger in a car for an hour without a break	0 1 2 3
Lying down in the afternoon when circumstances permit	0 1 2 3
Sitting and talking to someone	0 1 2 3
Sitting quietly after a lunch without alcohol	0 1 2 3
In a car while stopped for a few minutes in traffic	0 1 2 3
TOTAL	

Are you napping or dozing? Yes No
Do you have any drowsiness while driving? Yes No
How much caffeine do you drink? _____

Are you experiencing any problems with your CPAP? (Circle all that apply)

Mask problems:	Nasal symptoms:	Pressure problems:	Insomnia:	Other problems:
Skin irritation	Nasal/oral dryness	Too high	Falling asleep	Still snoring
Air leaks	Nasal congestion	Too low	Staying asleep	Eye irritation
Mask discomfort	Nose bleeds	Abdominal pain		Noise
				Moisture

Please complete the FOSQ form on reverse side if you haven't done so within the last 12 months. →
It is required by many insurances for continued resupply of PAP equipment.

PCCAB 410-832-3400 www.pccab.com

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Functional Outcomes of Sleep Questionnaire (FOSQ 10)

Question	**1-Yes Extreme**	**2-Yes Moderate**	**3- Yes A little**	**4- No**	**My score**
Do you have difficulty concentrating on the things you do because you are sleepy or tired?					
Do you generally have difficulty remembering things because you are sleepy or tired?					
Do you have difficulty operating a motor vehicle for short distances (less than 100 miles) because you become sleepy?					
Do you have difficulty operating a motor vehicle for long distances (greater than 100 miles) because you become sleepy?					
Do you have difficulty visiting your family or friends in their home because you become sleepy or tired?					
Has your relationship with family, friends, or work colleagues been affected because you are sleepy or tired?					
Do you have difficulty watching a movie or video because you become sleepy or tired?					
Do you have difficulty being as active as you want to be in the evening because you are sleepy or tired?					
Do you have difficulty being as active as you want to be in the morning because you are sleepy or tired?					
Has your mood been affected because you are sleepy or tired?					

Total Score: