Best health Sleep Center

www.bhscenter.com

Date

NAME:

Height:

Weight:

BMI :

When was CPAP therapy started

CPAP machine pressure setting if known. ……..cm H2O,

Heated humidifier Yes NO

Mask type __Full face __ Nasal __ Nasal pillow

__**S**mall __ **M**edium __ **L**arge

Average hours of CPAP use every night ? **3 – 4 hrs** **6 – 7 hrs** **8 or more hrs**

Average days of CPAP use each week? **0 1 2 3 4 5 6 7** Days a week

Do you benefit from use of CPAP ? Yes NO

Mask Issues
Leak if any
Size S/M/L
Allergy

Tube issues heated or not
Short or long
Water sound

Humidifier Issues
If any

_____

CPAP/Bipap Brand if known

Any concerns _____

O2 if any

Do you need to consider Oral device/Inspire or others

Any weight changes
Sinus
Gerd

Weight changes ◊ Same ◊ Lost . . . . . lb ◊ Gained . . . . . lb

Abdominal distension Yes No

Did you have cold or an other medical condition preventing regular use of CPAP describe. Yes No

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INSTRUCTIONS:
The following questions relate to your usual sleep habits during the past month only. Your answers should indicate the most accurate reply for the majority of days and nights in the past month. Please answer all questions.

1. During the past month, what time have you usually gone to bed at night?

BED TIME _____

2. During the past month, how long (in minutes) has it usually taken you to fall asleep each night?

NUMBER OF MINUTES _____

3. During the past month, what time have you usually gotten up in the morning?

GETTING UP TIME _____

4. During the past month, how many hours of actual sleep did you get at night? (This may be different than the number of hours you spent in bed.)

HOURS OF SLEEP PER NIGHT _____

For each of the remaining questions, check the one best response. Please answer all questions.

5. During the past month, how often have you had trouble sleeping because you . . .

a) Cannot get to sleep within 30 minutes

Not during the past month_____ Less than once a week_____ Once or twice a week_____ Three or more times a week_____

b) Wake up in the middle of the night or early morning

Not during the past month_____ Less than once a week_____ Once or twice a week_____ Three or more times a week_____

c) Have to get up to use the bathroom

Not during the past month_____ Less than once a week_____ Once or twice a week_____ Three or more times a week_____

d) Cannot breathe comfortably

Not during the Less than Once or twice Three or more
past month_____ once a week_____ a week_____ times a week_____

e) Cough or snore loudly

Not during the Less than Once or twice Three or more
past month_____ once a week_____ a week_____ times a week_____

f) Feel too cold

Not during the Less than Once or twice Three or more
past month_____ once a week_____ a week_____ times a week_____

g) Feel too hot

Not during the Less than Once or twice Three or more
past month_____ once a week_____ a week_____ times a week_____

h) Had bad dreams

Not during the Less than Once or twice Three or more
past month_____ once a week_____ a week_____ times a week_____

i) Have pain

Not during the Less than Once or twice Three or more
past month_____ once a week_____ a week_____ times a week_____

j) Other reason(s), please describe_____

_____

How often during the past month have you had trouble sleeping because of this?

Not during the Less than Once or twice Three or more
past month_____ once a week_____ a week_____ times a week_____

6. During the past month, how would you rate your sleep quality overall?

Very good _____

Fairly good _____

Fairly bad _____

Very bad _____

7. During the past month, how often have you taken medicine to help you sleep (prescribed or "over the counter")?

Not during the past month_____ Less than once a week_____ Once or twice a week_____ Three or more times a week_____

8. During the past month, how often have you had trouble staying awake while driving, eating meals, or engaging in social activity?

Not during the past month_____ Less than once a week_____ Once or twice a week_____ Three or more times a week_____

9. During the past month, how much of a problem has it been for you to keep up enough enthusiasm to get things done?

No problem at all _____

Only a very slight problem _____

Somewhat of a problem _____

A very big problem _____

10. Do you have a bed partner or room mate?

No bed partner or room mate _____

Partner/room mate in other room _____

Partner in same room, but not same bed _____

Partner in same bed _____

If you have a room mate or bed partner, ask him/her how often in the past month you have had . . .

a) Loud snoring

Not during the past month_____ Less than once a week_____ Once or twice a week_____ Three or more times a week_____

b) Long pauses between breaths while asleep

Not during the Less than Once or twice Three or more
past month_____ once a week_____ a week_____ times a week_____

c) Legs twitching or jerking while you sleep

Not during the Less than Once or twice Three or more
past month_____ once a week_____ a week_____ times a week_____

d)
e)
Episodes of disorientation or confusion during sleep
Not during the
Less than
Once or twice
past month_____ once a week_____ a week_____
Three or more
times a week_____
Other restlessness while you sleep; please describe_____
_____
Not during the
Less than
Once or twice
past month_____ once a week_____ a week_____
Three or more
times a week_____