SLEEP MEDICINE ASSOCIATES OF TEXAS, P.A.

Name: _____ Date: _____
DOB:_____

Since you are on CPAP, how likely are you to doze off or fall asleep at each specified time of the day (in the morning, afternoon, and evening) in each of the following situations?
For each time of the day, use the following scale to choose the most appropriate rating for each situation:

0= Would never doze
1= Slight chance of dozing
2= Moderate chance of dozing
3= High chance of dozing

Situation	***Morning*** *Before noon*	***Afternoon*** *Noon-6pm*	***Evening*** *After 6 pm*
Sitting & reading……..			
Watching TV……			
Sitting inactive in a public place (i.e. theater)……			
As a car passenger for an hour without a break……			
Lying down to rest……			
Sitting & talking to someone……			
Sitting quietly after a meal without alcohol……			
In a car, while stopping for a few minutes in traffic……			
Total			

Changes to system since last visit?
(blower, mask, humidifier, etc.)?_____

Complications? Please (circle) any of the following that have been a **persistent** problem for you **while using CPAP**:

headgear fitting skin irritation sinus drainage congestion morning headaches ear congestion

snoring breathing pauses dry mouth dry nose/throat machine noises mask noises

nasal irritation increased gas or burping other_____

How many nights a week do you use the machine? _____ Hrs of use per night: _____

Additional comments: _____
_____

Try to be specific with the following questions). Please rate your answer based on your average night.

1) What time do you usually go to bed?_____a.m./p.m. What time do you arise for the day? _____a.m./p.m.
2) How long does it usually take you to fall asleep after deciding to go to sleep? _____min.
3) How many times do you wake up during a typical night? _____times.
4) What is the total hrs. of sleep that you usually get at night? _____hrs.