

SLEEP MEDICINE: PATIENT FOLLOW-UP QUESTIONNAIRE

Name _____

Date _____

Part 1:

Has anything changed in your medical/surgical history since your previous office visit? Y N
If yes, please explain _____

Please list your medications: _____

No change
from last visit

Part 2: [If you have obstructive sleep apnea please complete this section, if not, skip to **Part 3**]

Number of nights per week you wear CPAP _____
Roughly, what time do you go to sleep at night? _____
Roughly, what time do you get up and start your day? _____
How many hours per night do you wear CPAP? _____

What are you using? Full-face mask Nasal Mask Nasal Pillows Chin Strap

What is your CPAP device's current pressure setting? _____

- | | | |
|---|---|---|
| 1. Are you snoring with use of CPAP? | Y | N |
| 2. Are you noticing the collection of any water droplets in the mask or tubing? | Y | N |
| 3. Does the mask feel too tight? | Y | N |
| 4. Is the mask leaving red marks on your face? | Y | N |
| 5. Does the mask leak? | Y | N |
| 6. Does your mouth or lips feel dry when you wake up? | Y | N |
| 7. Does your nose feel more congested when you wear the CPAP device? | Y | N |
| 8. Is your mouth opening at night while you sleep? | Y | N |
| 9. Do you feel that CPAP is helping you? | Y | N |

In what way? _____

10. If you are experiencing any other problems with the CPAP device please explain:

Physician Signature/Initials _____

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Part 3:

HOW LIKELY ARE YOU TO DOZE OFF OR FALL ASLEEP (NOT JUST FEEL TIRED) IN THE FOLLOWING SITUATIONS? *Note: this refers to your usual way of life in recent times. If you have not done some of these things recently, try to determine the ways in which you might be in these situations.*

	No chance	Slight chance	Moderate chance	High chance
Sitting and reading	0	1	2	3
Watching TV	0	1	2	3
Sitting inactive in a public place (like a theater or a meeting)	0	1	2	3
Riding as a passenger in a car for an hour without a break	0	1	2	3
Lying down to rest in the afternoon when circumstances permit	0	1	2	3
Sitting and talking to someone	0	1	2	3
Sitting quietly after lunch without alcohol	0	1	2	3
In a car, while stopped for a few minutes in traffic	0	1	2	3
				/24
At the dinner table	0	1	2	3
While driving	0	1	2	3

Fatigue Severity Scale

During the past week I have found that :

	Disagree ----- Agree						
	1	2	3	4	5	6	7
1. My motivation is lower when I am fatigued	1	2	3	4	5	6	7
2. Exercise brings on my fatigue	1	2	3	4	5	6	7
3. I am easily fatigued	1	2	3	4	5	6	7
4. Fatigue interferes with my physical functioning	1	2	3	4	5	6	7
5. Fatigue causes frequent problems for me	1	2	3	4	5	6	7
6. My fatigue prevents sustained physical functioning	1	2	3	4	5	6	7
7. Fatigue interferes with carrying out certain duties and responsibilities	1	2	3	4	5	6	7
8. Fatigue is among my three most disabling symptoms	1	2	3	4	5	6	7
9. Fatigue interferes with my work, family, or social life.	1	2	3	4	5	6	7

Total Score_____

Part 4: Are you having any other problems with your sleep that you would like addressed today?