Pacific Sleep Program • Portland & Astoria

FOLLOW-UP QUESTIONNAIRE

Name: ______________________________ **Date of birth:** ___/___/___ **Current weight:** ____ **lbs.**

THE EPWORTH SLEEPINESS SCALE

How likely are you to doze off or fall asleep in the following situations? Even if you have not done some of these things recently, give a general estimate for each situation.

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

Situation	Chance of dozing (0–3)			
	Never	***Slight***	***Moderate***	***High***
Sitting and reading	☐ 0	☐ 1	☐ 2	☐ 3
Watching TV	☐ 0	☐ 1	☐ 2	☐ 3
Sitting, inactive in a public place (e.g., a theater or a meeting)	☐ 0	☐ 1	☐ 2	☐ 3
As a passenger in a car for an hour without a break	☐ 0	☐ 1	☐ 2	☐ 3
Lying down to rest in the afternoon when the 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
TOTAL (add up your scores)	________			

Please complete the following questions about your sleep patterns as best you can.

	Bedtime	**Rise time**	**How long it takes to fall asleep**
Typical sleep schedule on work days	____:____	____:____	
Typical sleep schedule on days off	____:____	____:____	

How many times do you usually wake up out of sleep, even if just momentarily? ____________________

Once you awaken during the night, how long does it typically take to fall back asleep? _______________

Do you nap? ☐ Yes ☐ No If **Yes**, how frequently do you nap? ________________________________

How long are your naps? ____

Do you have a commercial driver's license (truck, bus, etc.) or pilot's license? ☐ Yes ☐ No

Do you feel drowsy while driving? ☐ Yes ☐ No

Have you had any health changes since your last visit? ☐ Yes ☐ No

Have you had any weight changes since your last visit? ☐ Yes ☐ No

Do you use pills (prescription or over-the-counter) or other substances to help you sleep? ☐ Yes ☐ No

Are there specific issues you wish to address today (restless legs, insomnia, etc.)? ☐ Yes ☐ No

If you are on PAP (positive airway pressure) therapy, please complete the second page. —>

PAP (POSITIVE AIRWAY PRESSURE QUESTIONS

Where do you currently get your mask and PAP supplies?

☐ Pacific Sleep Program ☐ Sleep Technologies ☐ Norco ☐ Lincare ☐ Providence

☐ North Coast Home Care ☐ Apria ☐ Quest ☐ Tuality ☐ Other: _______________

Approximate age of machine ________ years

Has your PAP device had any malfunctions? ☐ No ☐ Yes

Do you anticipate any changes in your insurance in the next year? ☐ No ☐ Yes

Are you comfortable with the PAP pressure? ☐ Yes ☐ No

Are you having problems with significant air swallowing/aerophagia? ☐ No ☐ Yes

Name and size of your mask, if known: ____

Are you satisfied with the fit of your mask interface? ☐ Yes ☐ No

Do you use a chin strap? ☐ No ☐ Yes

If **Yes**, please check one: ☐ White ☐ Black ☐ Ruby ☐ Tan

Are you having any mask leak or facial/eye irritation issues? ☐ No ☐ Yes

Are you having any problems with dry mouth? ☐ No ☐ Yes

Are you using any mask liners or pads? ☐ No ☐ Yes

If **Yes**, please list what you're using: ____

When did you last replace your mask interface cushion?

☐ Less than 1 month ago ☐ 1–3 months ago ☐ 3–6 months ago

☐ +6 months ☐ Have not yet replaced (new setup)

How often do you clean your mask cushion? ☐ Daily ☐ Weekly ☐ Monthly ☐ Other

What do you use to clean your supplies? ☐ Dish soap ☐ CPAP wipes ☐ SoClean ☐ Other

Do you have any other concerns or questions about PAP therapy or sleep apnea? ☐ No ☐ Yes

If **Yes**, please list them here: ____

____

Please return the completed form to the front desk for your
sleep medicine clinician to review prior to your visit.