Name:______________________________________ Date of Birth:_____/_____/_____ Today's Date:_____/_____/_____

Sleep Follow-up Questionnaire

Do you use CPAP, BiPAP, BiPAPst, ASV, AVAPS, Trilogy? □ No □ Yes

If yes, does oxygen bleed into your machine? □ No □ Yes; how much _______L

Do you use a dental appliance for your sleep apnea? □ No □ Yes

Please answer the following questions with the numerical response as follows:

0=would never doze 1=slight chance of dozing 2=moderate chance of dozing 3=high chance of dozing

_____ Sitting and reading
_____ Watching TV
_____ Sitting inactive in a public place (i.e. a theater, a meeting)
_____ As a passenger in a car for an hour without a break
_____ Lying down to rest in a the afternoon when circumstances permit
_____ Sitting and talking to someone
_____ Sitting quietly after lunch without alcohol
_____ In a car, while stopped for a few minutes in traffic

When you wake do you have a dry mouth? □ No □ Yes

When you wake do you have a sore throat? □ No □ Yes

Do you have daytime sleepiness? □ No □ Yes

What DME company supplies your machine and maintenance? ____