McLAREN FLINT
Flint, Michigan
SLEEP DIAGNOSTIC CENTER
CPAP FOLLOW-UP STUDY QUESTIONNAIRE

Name: _____ *Date:* _____ / _____ / _____

CIRCLE ONE ANSWER PER QUESTION.

1. On an average, how many nights a week do you use CPAP?

0 1 2 3 4 5 6 7

2. How many hours each night, on an average, do you use CPAP?

0 1 2 3 4 5 6 7 8 9 10

3. How much benefit do you think you had from using CPAP? 0 = no benefit at all, 10 = I am completely cured

0 1 2 3 4 5 6 7 8 9 10

4. How much discomfort do you have from using CPAP? 0 = I cannot use it at all, 10 = I have no problems at all

0 1 2 3 4 5 6 7 8 9 10

Please describe what type of discomfort you experience: _____

_____

_____

5. How long have you been using (or trying to use) CPAP? _____

6. Have you had any changes in your weight or health, or have you had any corrective surgery on your nose or throat?

_____

_____

_____

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M-17332 (10/14)

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PT.

MR.#/P.M.

DR.