TO RETURN THE QUESTIONAIRE:

Fax to 413-787-5713 **OR**

Email to nlw4@baystatehealth.org (This is not HIPPA secure). Do not send other medical questions to this email **OR**

Sent back securely on the Baystate Health Portal using the following directions

1. Connect to your portal account at mybaystatehealth.org
2. Create new message addressed to Karin G Johnson, Sleep Medicine or to your provider if known
3. Select all- Control A, Then Copy- Control C, then paste-Control V into message and Send

If you are not contacted within 2 business days to schedule your appointment or need help, please call 413-794-5600

Followup Patient Sleep Questionnaire

Patient Name: _____ **Date of Birth:** _____ **Date:** _____

Insurance: _____ **Pharmacy:** _____ **Best Phone #:** _____

Weight: **(lbs.)** **Home Care Company:** _____

Please estimate how likely you would be to **nod off or fall asleep** in the following scenarios **recently:**

0 = Never **1 = Rarely** **2 = Sometimes** **3 = Frequently** **N/A = Not Applicable**

Sitting & reading	
Watching television	
Sitting inactive in a public place (i.e., theater)	
Passenger in a car for an hour without a break	
Lying down to rest in the afternoon	
Sitting and talking to someone	
Sitting quietly after a lunch without alcohol	
In a car, while stopped for a few minutes in traffic	
Total Score	

Sleep Schedule:

On **week or work** days, I typically go to bed at _____ and wake at _____ and sleep _____ hours.

On **weekends**, I typically go to bed at _____ and wake at _____ and sleep _____ hours.

It typically takes me _____ ☐minutes or ☐ hours **to fall asleep**.

I typically **wake** _____ times **at night** and it takes _____ minutes or hours **to fall back** to sleep.

I typically **use the bathroom** _____ times at night.

I typically **nap** for _____ amount of time _____ days per week.

Do you have any changes in your medications OR new medical problems?

_____

Current Tobacco: ☐ Yes # packs per day

Do you have any trouble tolerating CPAP/BIPAP? ☐ Yes ☐ No, Check why:

☐ Skin irritation ☐Leakage ☐Mask too tight ☐Loose or uncomfortable headgear

☐ Dry mouth ☐Condensation in tubing ☐ Machine too noisy ☐ Pressure seems excessive

☐ Pressure seems too weak/not enough air ☐ can't exhale easily ☐ Air too cold

☐Other: