How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired?

This refers to your usual way of life in recent times. Even if you have not done some of these things recently, try to work out how they would have affected you.

Use the following scale and choose the most appropriate number for each situation:

Sitting and reading _____
Watching TV_____
Sitting inactive in a public place
(e.g. A theater or a meeting)_____
As a passenger in a car for
an hour without a break_____
Lying down to rest in the
afternoon when circumstances_____
permit
Sitting and talking to someone_____
Sitting quietly after a lunch
without alcohol_____
In a car, while stopped for a
few minutes in traffic_____

0 = Would **never** doze

1= **Slight** change of dozing

2 = **Moderate** chance of dozing

3 = **High** chance of dozing

IF YOU HAVE NOT WORN A CPAP DEVICE, SKIP THIS SECTION

CPAP HISTORY:

YES NO Do you wear a CPAP device **successfully** during sleep?
How many hours per night do you wear your CPAP?_____
YES NO Have your tried other therapies for your sleeping disorder?
Please list other therapies (Weight-loss attempts, smoking cessation, surgeries, etc.)
_____

If you are unable to wear a CPAP device, please check below the reasons for your difficulty.

- ☐ Mask Leaks
- ☐ Mast Uncomfortable/Device Uncomfortable
- ☐ Unable to sleep comfortably
- ☐ Noise disturbs my sleep and/or bed partner's sleep
- ☐ Restricts movement during sleep
- ☐ Does not seem to be effective
- ☐ Straps/Headgear cause discomfort
- ☐ Pressure on the upper lip causes tooth related problems
- ☐ Latex Allergy
- ☐ Claustrophobia
- ☐ Other_____
  _____

I certify that the above information is correct to the best of my knowledge.

PATIENT SIGNATURE_____ DATE:_____