

## WELLNESS QUESTIONNAIRE

**Name:** Lamis ismail

**Date of birth:** 09-21-1980

**1- Are you currently wearing your CPAP mask every night?** yes

If no, why? I don't know

**2- Are you having any problems with it?** no

**Details:** Did not try it before

**3- Do you feel any better since starting on the CPAP machine?** no

**Details:** i have no idea

**4- When using your CPAP do you have any of the following complaints?**

YES Snore

YES Choke

YES Heartburn

YES Dry mouth

YES Morning headaches

YES Toss and turn in bed

**5- How many hours are you using your machine?** 6

**6- Are you using the humidifier on your machine?** no

**7- Have you lost or gained weight since starting the CPAP?** no

**8- Do you need any supplies yes or no If yes, please mark below supplies needed yes**

NO Mask

NO Headgear

YES Filters

YES Hoses

**Rate your chance of dozing in the situations below using the following scale:**

0=has not happened to me this past year and I do not think it would

1=has happened a time or two in the last year or has a slight chance of happening

2=has happened on occasion in the last few months and is likely to happen again

3=happens frequently and will happen again

3 When reading

3 When watching TV

3 When inactive in a public place (theater, at a meeting or lecture)

0 While waiting (at a stop light, at a doctor office)

0 While lying down to rest or take a break during the day

0 While sitting and talking to someone in person or on the phone

0 While sitting quietly during the day after eating

0 When riding as a passenger in a car, train, or plane for an hour or more

0 While driving a vehicle

9 TOTAL

**Comments or questions** Just a test

X I certify that all information is correct and complete. if any information would change, I will notify this office immediately

**DATE:** January 8, 2013, 4:36 pm