NAME: ....

DOB: ....

MRN: ....

somnoware

CPAP Tolerance Questionnaire

July 16, 2020

Rate your overall tolerance of CPAP *

- [ ] Excellent
- [ ] Very Good
- [ ] Fair
- [ ] Marginal
- [ ] Poor

How did CPAP treatment affect your sleep quality last night? *

- [ ] Greatly Better
- [ ] Moderately Better
- [ ] Mildly Better
- [ ] Unchanged
- [ ] Made it worse

How likely are you to use CPAP at home on the long term? *

- [ ] Definitely yes
- [ ] Very likely
- [ ] Quite likely
- [ ] Maybe
- [ ] Unlikely
- [ ] Definitely not

How did you find the mask (If more than one mask was used, rate your tolerance of the best mask)? *

- [ ] Very comfortable
- [ ] Comfortable
- [ ] OK
- [ ] Mildly uncomfortable
- [ ] Very uncomfortable

If the mask was uncomfortable, which of the following was a problem? *

- [ ] Pressure over bridge of nose
- [ ] Pressure on lip
- [ ] Pressure on nostril
- [ ] Pressure on forehead
- [ ] Claustrophobia

Any additional comments on CPAP: *

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