# Granger Medical Clinic

**West Jordan, Utah**

*A Member of the Granger Medical Family*

*Pulmonary & Sleep*
*Dr. Sandeep Chowdhary*
*Cassie Port, FNP-C*

*ACCT #:* _____

## CPAP Therapy Evaluation and Follow-Up Form

Today's Date: _____

| Name: | DOB: |
|---|---|

How long have you had your CPAP machine? (Week or Month) _____

Are you currently using your CPAP machine? Yes ❑ No ❑

How many nights per week do you use your CPAP? _____

How many hours per night do you use your CPAP? _____

### Are you Dozing off when?

**Key for the next questions:**

**0- being never and 3-being all the time**

| | | | | |
|---|---|---|---|---|
| **Sitting, inactive and/or reading?** | **0** | **1** | **2** | **3** |
| **Watching TV?** | **0** | **1** | **2** | **3** |
| **Sitting, inactive in a public place?** | **0** | **1** | **2** | **3** |
| **As a passenger in a car, for an hour without a break?** | **0** | **1** | **2** | **3** |
| **Lying down to rest in the afternoon when circumstances permit?** | **0** | **1** | **2** | **3** |
| **Sitting and talking with someone** | **0** | **1** | **2** | **3** |
| **Sitting quietly after lunch without drinking any alcohol?** | **0** | **1** | **2** | **3** |
| **In a car, while stopped for a few minutes in traffic?** | **0** | **1** | **2** | **3** |

****Please turn the page over to provide us with a brief description on your CPAP experiences****

**From the time you started using CPAP:**

1. Do you sleep better? Yes ❑ No ❑
2. Do you sleep longer? Yes ❑ No ❑
3. Do you feel more energy during the day? Yes ❑ No ❑
4. Do you feel less tired during the day? Yes ❑ No ❑

**Provide a brief description on your benefits and/or problems with the CPAP:**

_____

_____

_____

_____

**Provide a brief description on your benefits and/or problems with the Mask:**

_____

_____

_____

_____

## Office use only:

1. ResMed S9 Elite S9 Escape S9 Auto Set S9 VPAP

   Other : _____

2. Respironics System One BiPAP Auto SV Other: _____

3. Fisher & Paykel Other: _____

Mask : _____