WOULD YOU PLEASE HELP US IMPROVE THE CARE OF SLEEP APNEA?

You are being asked to complete a short packet of questionnaires because you are being evaluated for CPAP treatment of your sleep apnea. The answers that you provide will allow America's Favorite Sleep Center and the companies that provide CPAP devices to improve care of patients. **The questionnaires will take less than 5 minutes!!**

The questions that follow are aimed at finding out the factors that relate to your acceptance of CPAP. Your honest answers will truly be of help to us in finding ways to make treatment of sleep apnea more successful.

Some of these questions may seem like repeats, like you have seen them and answered them before. **We ask you please to be patient and complete the questionnaires as they are presented** because many of the questions are part of validated surveys that must be given in a packet or a group to be correctly interpreted.

If you do choose a trial of CPAP treatment at home, we will ask you to complete the questionnaires a second time, at a time point 3 to 4 months from now, in order to learn how you are doing and whether or not the CPAP treatment is making a difference in your life.

Again, thanks for taking the time to answer these questions honestly as we believe we can use the information to improve patient care.

Sincerely,

The Quality Assurance Team at America's Favorite Sleep Center

CPAP QUALITY ASSURANCE PROJECT
(All information will be safeguarded and kept confidential.)

1. Gender (circle): Female Male

2. Age: _____ years

3. Ethnic origin (circle only one):

White Black Hispanic Asian or Pacific Islander

Filipino American Indian/Alaskan Native

Other: _____ Prefer not to answer

4. What is the highest level of schooling you have completed?

Less than high school High school or GED Some college

Associates degree (2 years) Bachelor's degree (4 years) Graduate degree

5. Are you currently (circle only one)

Married Single Separated Other _____

6. What is your annual household income? (circle)

Less than $20, 000 $20,000 - $40,000 $40,000 - $60,000

$60,000 - $80,000 $80,000 - $100,000 Over $100,000

7. Are you currently taking sleep aids (sleeping pills)? If yes, please specify the medication:

Yes (Name of medication: _____, & how often? _____)

No

8. Please list all medications you are currently taking:

_____ _____

_____ _____

_____ _____

_____ _____

9. Have you ever been diagnosed with insomnia?

Yes No Not diagnosed, but I believe I have insomnia

10. Have you ever been diagnosed with claustrophobia (fear of enclosed spaces)?

Yes No Not diagnosed, but I believe I have claustrophobia

11. How successful do you believe CPAP therapy will be in improving how you feel?

Very successful Successful No effect Not successful Unsure

12.

Epworth Sleepiness Scale:

How likely are you to fall asleep in the following situations?

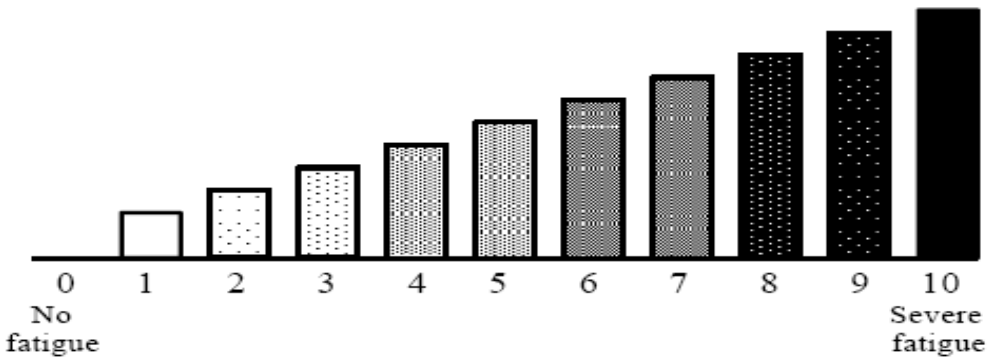
0 = *never* 1 = *slight* chance 2 = *moderate* chance 3 = *high* chance

Situation	**Chance of Dozing**
Sitting and reading	_____
Watching TV	_____
Sitting, inactive in a public place (e.g. 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 the traffic	_____

13.

Fatigue Scale

Please circle the number below that describes your fatigue over the past 2 weeks.



14. FUNCTIONAL OUTCOMES OF SLEEP QUESTIONNAIRE (FOSQ)	(0) I don't do this activity for other reasons	(4) No difficulty	(3) Yes, a little difficulty	(2) Yes, moderate difficulty	(1) Yes, extreme difficulty
1. Do you have difficulty concentrating because you are sleepy or tired?	□	□	□	□	□
2. Do you have difficulty remembering things because you are sleepy or tired?	□	□	□	□	□
3. Do you have difficulty driving short distances (<100 miles) because you're tired?	□	□	□	□	□
4. Do you have difficulty driving long distances (>100 miles) because you're tired?	□	□	□	□	□
5. Do you have difficulty visiting with your family or friends in their home because you become sleepy or tired?	□	□	□	□	□
6. Has your relationship with family, friends or colleagues been affected because of sleepiness?	□	□	□	□	□
7. Do you have difficulty watching a movie or videotape because you become sleepy or tired?	□	□	□	□	□
8. Do you have difficulty being as active as you want in the evening because you're sleepy?	□	□	□	□	□
9. Do you have difficulty being as active as you want in the morning because you're sleepy?	□	□	□	□	□
10. Has your desire for intimacy or sex been affected because you are sleepy or tired?	□	□	□	□	□