



Cardio-Respiratory Pre-Nap Questionnaire

Last Name: _____	First Name: _____	DOB: _____	Age: _____
Today's Date: _____	SSN: _____	Gender: _____	Height: _____
	Race: _____	Weight: _____	

I used my CPAP/BiPAP machine for _____ hours last night

My current CPAP/BiPAP pressure is _____ cm of water.

Please mark any of the issues that are preventing you from tolerating CPAP/BiPAP therapy:

Mask Discomfort Trouble Exhaling Pressure feels too high/low Anxiety

Other: _____

Current Status: Complete this section on the day of your study

When did you go to bed last night: _____ When did you wake up this morning? _____

If you took naps today, when and how long? _____

Are you in any pain today? No Yes: _____

Allergies

Are you allergic to tapes or adhesives? No Yes Are you allergic to Latex? No Yes

Please list any other allergies you have:

Diet and Medications

Estimated number of caffeinated beverages and foods (chocolates) per week: _____

Medications: Please list all below:

20.0019



Olathe Medical Center

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CARDIO-RESPIRATORY PRE NAP QUESTIONNAIRE

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O.M.C. No. 2110

PLACE
PATIENT LABEL
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