

1. Since your last sleep study, has your weight changed? ☐ yes ☐ no

If yes, how much weight have you gained/lost? _____

2. Since your last sleep study, have you had nasal or throat surgery? ☐ yes ☐ no

If yes, who performed the surgery, what did you have done and when did you have your surgery: _____

3. Are you currently supposed to be using CPAP/BiPap? ☐ yes ☐ no

If yes, do you use it regularly? ☐ yes ☐ no

If not, please describe why: _____

4. Have you had your machine checked recently by your home equipment company to make sure that it is working properly? ☐ yes ☐ no

5. What is the name of the home equipment company that provides you with your CPAP/BiPap?: _____

6. Have your symptoms improved from your last study? ☐ yes ☐ no

If not, what are your major symptoms at this time? ☐ Snoring ☐ Excessive sleepiness during the day

☐ Restless sleep ☐ Other, please describe: _____

7. Have there been any major health changes since your last sleep study? ☐ yes ☐ no

If yes, please describe: _____



Mary Lanning
HEALTHCARE



★ C P - 8 5 0 ★

Repeat Sleep Study Questionnaire

*Sleep Diagnostic Clinic –
Cardiopulmonary*

Created: 11/07

Revised: 04/08, 12/12