CPAP Comfort Questionnaire

Please fill in the following details:

Name:_____ **Date**:_____

Current Mask: nasal mask / nasal mask with chinstrap / oro-nasal mask (*please circle one*)

This is a list of problems people may experience when using CPAP. Please read the list and tick the box which describes if each item has been a problem for you during the last four weeks.

Problem	**Yes**	**No**
1. Facial soreness from mask pressure		
2. Skin irritation from the mask		
3. Trouble keeping the mask in place		
4. Air leaks from the mask		
5. Difficulty putting the mask on		
6. Claustrophobia from the mask		
7. Dry mouth or throat		
8. Dry or blocked nose		
9. Difficulty breathing out		
10. Sore eyes due to CPAP use		
11. Noisy CPAP mask		
12. If you had a CPAP mask problem not included on this list please describe it.		

The following questions relate to your CPAP use during the last four weeks.
Please place a mark across the line for each question to indicate your answer.

0 is the worst possible level, and 10 is the best possible level.

13. How satisfied were you with the mask?

_____

0 10

14. How refreshed did you feel after waking in the morning?

_____

0 10

15. How restful was your sleep?

_____

0 10