**Additional file 1: Post-trial questionnaire**

**Post-trial Questionnaire**

How comfortable did you feel overall during your use of the CPAP system? (1 – not at all comfortable; 5 – very comfortable)

1 2 3 4 5

To what degree did you experience any of the following feelings? (1 – not at all; 5 – strongly)

Claustrophobia

1 2 3 4 5

Anxiety

1 2 3 4 5

Breathlessness

1 2 3 4 5

Dizziness

1 2 3 4 5

Do you have any prior personal experience using CPAP devices?

Do you have any additional feedback you wish to share with the research team? (write below)