Blake Medical Center Sleep Disorders Center

Name: _____

1. How many hours did you sleep last night?
   - ☐ Less than 3 hours
   - ☐ 3-5 hours
   - ☐ 6-8 hours
   - ☐ More than 8 hours

2. How long do you think it took you to fall asleep last night? _____

3. How is this compared to the length of time it usually takes at home?
   - ☐ About the same
   - ☐ Longer than usual
   - ☐ Shorter than usual

3. How would you compare this to a normal night's sleep at home?
   - ☐ Same
   - ☐ Similar
   - ☐ Not at all similar

4. Do you feel refreshed this morning? ☐ Yes ☐ No

5. Did you have trouble falling asleep last night? ☐ Yes ☐ No
   If so, please explain _____

6. If you used CPAP last night, did you wake up feeling?
   - ☐ Better than normal
   - ☐ Worse than normal
   - ☐ About the same

7. Was the CPAP mask you used comfortable? ☐ Yes ☐ No
   If not, why? _____

8. How would you rate your overall experience with CPAP?
   - ☐ Good
   - ☐ Fair
   - ☐ Poor

9. Do you have any physical complaints this morning? (headache, congestion, nausea, etc.)
   - ☐ Yes
   - ☐ No

   Please describe: _____

Patient Information/ Label

Post Sleep Questionnaire