

POST SLEEP STUDY QUESTIONNAIRE

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Please mark your answers and fill in the blanks where applicable.

1. How long did it take you to fall asleep last night? Immediately Few Minutes Hours
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2. How does this compare to the time it usually takes you to fall asleep? Shorter Same Longer
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3. How many hours do you think you slept last night?
-
4. How does this compare to the amount of sleep you usually get? More Same Less
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5. If you dreamt anything significant please explain.
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6. How many times do you remember waking up before the end of the study? Please explain the reason.
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7. How did you feel immediately after you woke up? Wide awake Somewhat alert Sleepy
-
8. In general, how did you sleep? Better Same as usual Poorly
-

Please answer questions 9-13 if you used a CPAP/BIPAP.

9. How did you tolerate the mask and pressure? Well Would need time to get used to. Poorly
-
10. Do you feel more rested this morning as compared to usual awakening in the morning? Yes No
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11. Do you think you snored less when using CPAP? Yes No
-
12. How did you sleep with CPAP? Better Same as usual Worse
-
13. Please explain any problems you had with the CPAP / BIPAP therapy:
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Patient Signature: _____ Date: _____

Technologist Signature: _____ Date: _____