MY SLEEP SERVICES

Post Sleep Study Questionnaire

Patient Name: _____ Date: _____

- How many hours do YOU think you slept last night? 4.00
- To you your last night sleep felt the same, shorter or longer than usual? longer
- How long do you think it took you to fall asleep last night?
- Was this the same, shorter or longer than usual?
- How many times do you remember waking up last night?
- How long do you remember being awake during the night?
- Did you have difficulty falling sleep in the middle of the night? Please explain.
- This morning, do you feel: ☐ more alert than usual ☐ same as usual ☐ less alert than usual
- Was last night's sleep quality better, worse or the same compared to usual? same
- What medication/supplements/sleep aids did you take prior to sleep last night?
- Did you use a sleep apnea device, snore guard, mouth guard, grinding guard, retainer, clear aligners during your sleep study?
- Do you have any comments about your study?

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