McLAREN FLINT
SLEEP DIAGNOSTIC CENTER
PATIENT POST-SLEEP STUDY QUESTIONNAIRE

Name: _____ Date: _____ / _____ / _____

1. How long did it take you to fall asleep last night?
   ❑ Immediately ❑ Few minutes ❑ Hours ❑ Did not fall asleep
   Please list any medications taken to help you sleep last night: _____ _____
   Type Time
2. How does this compare to the time it usually takes you to fall asleep?
   ❑ Same ❑ Shorter Time ❑ Longer time
3. How long do you believe you slept throughout the night? _____
4. How does this compare to the amount of sleep you normally get?
   ❑ Same ❑ Less than normal ❑ More than normal
5. How much do you remember dreaming?
   ❑ Not at all ❑ Less than usual ❑ More than usual
6. Did you experience any unusual muscle sensations or movements, sights or sounds? ❑ No Yes
   If yes, please explain: _____
   _____
7. If you experienced any pain or discomfort during the study or are in pain now, please explain: _____
   _____
8. How did you feel immediately after you woke up?
   ❑ Sleepy ❑ Physically fatigued but not sleepy ❑ Somewhat alert ❑ Wide awake
9. How did you feel 15 minutes after waking up?
   ❑ Sleepy ❑ Physically fatigued but not Sleepy ❑ Somewhat alert ❑ Wide awake
10. In general, how did you sleep?
    ❑ Poorly ❑ Same as usual ❑ Better

PLEASE ANSWER QUESTIONS 11-16 IF YOU USED CPAP/BIPAP.

11. How did you tolerate the mask and pressure? ❑ Poorly ❑ Well ❑ Very well
12. Do you feel rested? ❑ Yes ❑ No
13. How did you sleep with CPAP? ❑ Better ❑ Same as usual ❑ Worse
14. Please explain any problems you had with the CPAP therapy: _____
    _____

COMMENTS/SUGGESTIONS: _____
_____
_____

PT.
MR.#/P.M.
DR.