BCM
Baylor College of Medicine

Baylor College *of* Medicine - **SLEEP CENTER**

Post-Sleep Questionnaire

Patient Name: ____ **Date of Study:** _________________

Type of Study: ____ **Technician:** ___________________

How long did it take you to fall asleep? _____ Hrs. _____ Mins.

How did your sleep last night compare to your normal sleep at home? Longer Shorter Average

In your opinion, how much sleep do you feel you obtained last night? _____ Hrs. _____ Mins.

How does the length of sleep last night compare to at home? Longer Shorter Average

Mark on the scale below how you rate the quality of your sleep last night?

0	1	2	3	4	5	6	7	8	9	10
Poor					Average					Deep

How many times did you wake up last night? _____________________

In your opinion, what woke you up? _____________________

a. Did you wake up short of breath or smothering last night? _____ Yes _____ No

b. Did you wake up sweating? _____ Yes _____ No

c. Did you wake up with chest pain or heart palpitations? _____ Yes _____ No

d. Did you wake up earlier than desired? _____ Yes _____ No

e. Did you have difficulty returning to sleep? _____ Yes _____ No

f. Did you awaken in a state of panic or confusion? _____ Yes _____ No

Mark on the scale below how rested you feel this morning?

0	1	2	3	4	5	6	7	8	9	10
Very Sleepy			Still Sleepy		Average		Rested			Wide Awake

How does your sleep last night compare to your normal sleep at home? _____ Worse _____ Avg. _____ Better

Describe below any pertinent information or comments regarding your sleep evaluations:

____

If last night's evaluation was performed utilizing nasal CPAP or Bi-Level Therapy, please complete the following:

Did you tolerate the use of nasal CPAP therapy during your evaluation last night? _____ Yes _____ No

Will you comply with nasal CPAP if your physician prescribes this therapy for you? _____ Yes _____ No

Evaluate your sleep using nasal CPAP as it compares to your normal sleep at home: _____ Worse _____ Same _____ Better

Did you experience any degree of claustrophobia while using nasal CPAP? _____ Yes _____ No

Did you experience any nasal congestion or dryness while using nasal CPAP? _____ Yes _____ No

Did you experience any discomfort with the mask utilized with nasal CPAP? _____ Yes _____ No

Your comments regarding nasal CPAP therapy: ____

____

Patient Signature: ____________________________________ Date: ___________________