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CMD
Sleep Disorders Center

Patient Name: _____ Date of Birth ____ / ____ / _____

Patient Medical Record #: _____ Study Date ____ / ____ / _____

Bedtime Questionnaire

1. Has today been an unusual day in any respect, which will affect your sleep? Yes / No
If yes, describe_____
2. How much sleep did you have last night? _____Hours _____Minutes
3. Did you take any naps today? Yes / No At what time(s)? _____How long? _____
4. Did you have any alcohol today? Yes / No At what time(s)? _____How much? _____
5. Did you smoke any tobacco today? Yes / No At what time(s)? _____How much? _____
6. Did you have any caffeine today? Yes / No At what time(s)? _____How much? _____
7. Did you exercise today? Yes / No
8. Do you have physical discomfort now? Yes / No If yes, will it affect your sleep? _____
9. Do you feel ready for bed now? Yes / No If no, give reason_____
10. Did you take any medications today other than your regular medications? Yes / No
If yes, please state medication, dosage, time and purpose:
_____

Morning Questionnaire

11. How long did it take you to fall asleep last night? _____ hr ____ minutes.
12. How does this compare with the time it takes at home? Much Longer Longer SameShorter Much shorter
13. How long do you think you slept last night? _____ hr ____ minutes.
14. How does this compare with your total sleep at home? Much Longer Longer Same Shorter Much shorter
15. How many times did you awaken last night? _____ times
16. How do you feel right now? Please circle one. Very tired Awake, but not alert Rested Wide awake
17. Do you have physical discomfort this morning?Yes / No If yes, please describe:
_____
18. Do you recall any dreams last night? Yes / No If yes, please describe?
_____
19. What awakened you this morning? Other _____Noise____Discomfort_____Technician____Spontaneous_____
20. How would you compare last night to your sleep at home? Much Worse Worse SameBetter Much better
21 In the morning, when you wake up, do you have dry mouth? Yes/No

PAP Questionnaire

If you were started on PAP during the night, please answer below

22. Was it difficult getting used to PAP before going to bed? _____Yes _____No
2324. Did the PAP cause nasal congestion _____Yes _____No
25. Did PAP cause irritating nasal dryness _____Yes _____No
26. Was the PAP mask irritating? _____Yes _____No
27. Did the air pressure bother you? _____Yes _____No
28. Did the noise bother you? _____Yes ____No
29. How do you feel this morning? _____Better than usual _____Same _____Worse than usual
30. Did you have any difficulty with PAP during the night? _____Yes _____No

ADDITIONAL COMMENTS: