Infinity Sleep Solutions

"A Better Night's Sleep"

Patient Name :____ DOB:________________

Post-Sleep Questionnaire

1. How long did it feel like it took you to fall asleep last night? _____Hours ______Minutes

2. How long do you feel like you slept? _____Hours ______Minutes

3. How many times do you remember waking up last night? _____Times

4. How would you descibe the quality of your sleep last night?

☐ Better than usual ☐ The same as usual ☐ Worse than usual

5. How alert do you feel right now?

☐ Wide awake ☐ Awake, but not fully alert ☐ Sleepy and would prefer to go back to sleep.

6. Do you remember any dreams from last night? Yes_____ No______

Complete this section only if CPAP / BiPAP was used last night:

7. If you used CPAP / BiPAP last night, did you feel like the mask used was comfortable? Yes_____ No______

8. Would you be willing to use CPAP / BiPAP at home if prescribed to you? Yes_____ No______

Please do not forget to take your personal belongings with you.

Thank you for choosing Infinity Sleep Solutions to help you get "A Better Night's Sleep"!