Post Sleep Questionnaire

How many times did you awaken during the night? _____

Were these awakenings associated with any of the following:

- ☐ Pain
- ☐ Gasping
- ☐ Choking
- ☐ Snoring
- ☐ Headache
- ☐ Need to urinate
- ☐ Nightmares
- ☐ Leg discomfort
- ☐ Anxiety
- ☐ Heartburn

When you awoke in the morning did you have any of the following symptoms?

- ☐ Headache
- ☐ Dry mouth
- ☐ Sore throat
- ☐ Sore jaw

If you have a partner to ask, did they hear you snore or gasp for breath?

- ☐ Yes
- ☐ No

Comment: _____

Answer the following question using a scale from 1 to 5, where 1 indicates very poor and 5 indicates very well.

Questions	Rating
How well did you sleep last night?	1 2 3 4 5

Do you have any additional comments? _____

_____

_____

_____

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Sleep Log Documentation

Patient Name: _____

Date: _____

Start time: _____ End Time: _____

Gathering home sleep test information

For your at home sleep test, it's important to gather information on your activities before and during the sleep test. Certain activities, such as caffeine consumption can affect your sleep and subsequently the quality of your sleep test. Use this sleep log to help you note your activities before and during your sleep test. Having this information will help your doctor determine the accuracy of your sleep test results.

Sample Sleep Log

Time	Activity	
8:00 pm	Quantity *2* & type of beverage *alcoholic*, consumed before going to bed.	
10:30 pm	*Watched T.V. in bed*	
11:20 pm	Went to bed: ☑ with my oral appliance ☐ without my oral appliance	☑ with my CPAP ☐ without my CPAP
1:00 am	*Woke up and turned off the T.V.*	
5:00 am	*Used the bathroom*	
5:30 am	*Cat woke me up*	
	Fell back to sleep	
7:00 am	Woke up and started my day.	

Sleep Test Information

Sleep Position

In what position do you normally fall asleep?

☐ Right side
☐ Left side
☐ Back
☐ Stomach

Please fill out your sleep log to the best of your recollection, approximately indicating the times you were:

☐ Not sleeping
☐ Getting up for any reason
☐ Adjusting the MediByte
☐ Drinking liquids/eating food
☐ Taking medications
☐ Performing any activities

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Your Sleep Log

Time	Activity	
	Quantity _____ & type of beverage _____, consumed before going to bed.	
	Went to bed: ☐ with my oral appliance ☐ without my oral appliance	☐ with my CPAP ☐ without my CPAP
	Woke up and started my day.	