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 describe 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”!