

Piedmont Internal Medicine, Pulmonary And  
Infectious Diseases, PA.  
Post-Sleep Questionnaire

Patient Name: \_\_\_\_\_ Date of Study: \_\_\_\_\_

How long did it take for you to fall asleep last night? \_\_\_\_\_ Hours \_\_\_\_\_ Minutes

1 Compared to your usual sleep pattern, was it:

2 a. Shorter than normal      b. Longer than normal      c. The same

3 Aside from the monitoring devices, did you have difficulty falling asleep last night?

4 a. Yes      b. No

5 Did you wake up during the night?

6 a. Yes      b. No

7 If your answer to the previous question was yes, did you have difficulty returning to sleep?

8 a. Yes      b. No

9 How long did you sleep last night? \_\_\_\_\_ Hours \_\_\_\_\_ Minutes

10 How deeply do you feel that you slept last night?

11 a. Very deeply      b. Somewhat deeply      c. Average      d. Lightly      e. Very lightly

12 How alert do you feel right now?

a. Very      b. Somewhat      c. Average      d. Not very      e. Not at all

9. How sleepy do you feel right now?

a. Very      b. Somewhat      c. Average      d. Not very      e. Not at all

10. Did you dream last night?

1 a. Yes      b. N

11. Did you experience any unusual feelings or sensations upon awakening ?

1 a. Yes      b. N

12. If yes to the previous question, please describe below: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

13. How did you wake up this morning?

a. Technician      b. On my own      c. Noise      d. Uncertain

Please share any comments or suggestions regarding the lab, the staff, and/or your experience at out sleep facility: \_\_\_\_\_

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