WOOSTER COMMUNITY HOSPITAL

POST-SLEEP QUESTIONNAIRE

1. Did you have difficulty falling asleep last night? Yes _____No _____If yes, please Explain why _____

2. How long do you think it took you to fall asleep last night? _____Hrs. _____ Min.
   Compared to usual was this: longer_____ Same _____ Shorter _____

3. Did you wake up during the night? Yes _____ No _____ If yes, how many times _____

4. Did you have difficulty falling back to sleep? Yes _____ No _____

5. How long do you think you slept last night?_____
   Compared to usual was this Longer_____Same_____ Shorter _____

6. How deeply do you feel you slept Last night?
   Very deep_____Deep_____Average_____ Light _____Very light_____

7. How does your sleep last night compare to your usual sleep?
   Better_____ Same _____ Worse _____

8. How sleepy do you feel right now? Not at all_____ Little _____ Extremely _____

9. How tired to you feel right now? Not at all _____Little _____ Extremely _____

10. How alert do you feel right now? Not at all _____Little_____Extremely _____

11. Was there anything different about sleeping in the Sleep Lab? Yes _____No_____
    If yes, please explain _____

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