Pioneer Neurology and Sleep

299 Carew Street Suite 119 ;Springfield, MA 01104
Tel: 413-736-1500 ; Fax: 413-736-1600

*NAME:*_____ *DATE:*_____ *#*_____

1. *How long did it take you to fall asleep last night? (Give your best guess in minutes or hours)*_____
2. *How many hours of sleep did you get during the night?*

   _____
3. *How much time were you awake during the night?*

   _____

Please answer the following questions according to this scale:

1 – Not at all 2 – Slightly 3 – Moderately 4 – Considerably

1. *How refreshing was your sleep last night?*	*1*	*2*	*3*	*4*
2. *How sound was your sleep last night?*	*1*	*2*	*3*	*4*
3. *How rested do you feel this morning?*	*1*	*2*	*3*	*4*
4. *How tired do you feel this morning?*	*1*	*2*	*3*	*4*
5. *How sleepy do you feel this morning?*	*1*	*2*	*3*	*4*
6. *How alert do you feel this morning?*	*1*	*2*	*3*	*4*
7. *How disturbing were your dreams last night?*	*1*	*2*	*3*	*4*

In comparing your sleep last night to the way you usually sleep (over the past several weeks), please use the following scale:

1 – Much less than usual 2 – Less than usual 3 – Same as usual
4 – More than usual 5 – Much more than usual

1. *How long did it take you to fall asleep?*	*1*	*2*	*3*	*4*	*5*
2. *How much did you stay asleep?*	*1*	*2*	*3*	*4*	*5*
3. *How much time were you awake during The night?*	*1*	*2*	*3*	*4*	*5*
4. *If you did awaken, how difficult was it to Return to sleep?*	*1*	*2*	*3*	*4*	*5*
5. *How rested do you feel this morning?*	*1*	*2*	*3*	*4*	*5*

*Overall comments:*_____

Please answer the following questions ONLY if you used the nasal CPAP unit:

1. *Do you feel that the CPAP unit helped you to sleep better? Yes*_____ *No*_____
2. *Would you be willing to use nasal CPAP in your home on a nightly basis? Yes*__ *No*__