TEL: (925) 935-7667 FAX: (925) 945-7667
www.ccsleepcenter.com
info@ccsleepcenter.com

POST SLEEP STUDY QUESTIONNAIRE

Date:_____

Good Morning!

Please take a few minutes to fill out this morning questionnaire.

This is not a test, so just fill out the answers the best that you can.

Don't forget to write and sign your name where indicated.

Thank You.

Your attending technician for today is:_____

****

Your referring physician will receive your results when they have been completed. If you haven't done so already, please make sure you schedule your follow up appointment. If you would like to receive a copy of your sleep study test results, please select one of the following options:

□ My Chart Message (electronically; must have MyChart account)

□ Mail: Please fill out the attached envelope; If not, you may leave the envelope blank

□ Fax: Please list fax #_____

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Patient Name:_____Date of Study:_____ Technician:_____

PLEASE TAKE A FEW MINUTES TO COMPLETE THIS QUESTIONNAIRE SO WE CAN SEE WHAT KIND OF A JOB WE ARE DOING.

OFFICE STAFF

Poor (1) to Excellent (5)

1. Was your call handled in a courteous, helpful manner? 1 2 3 4 5
2. Did you receive a call to remind you of your appointment? Yes_____ No_____
3. Did you receive your questionnaires in the mail/fax/email? Yes_____ No _____

TECHNICAL STAFF

1. How well did the Technician explain the testing procedure? 1 2 3 4 5
2. How courteous was the Technician? 1 2 3 4 5
3. How professional was the Technician? 1 2 3 4 5
4. Did the Technician explain and demonstrate Nasal CPAP/BIPAP? Yes_____ No_____
   (*If this was a CPAP/BIPAP or Split night study*)
5. Was the Technician on time? Yes_____ No_____

TESTING AREA

1. How was the comfort and cleanliness of the facility? 1 2 3 4 5
2. How comfortable was the bed? 1 2 3 4 5
3. How quiet was the facility? 1 2 3 4 5

Thank you for choosing our service. We are dedicated to providing excellent service. Your comments allow us to ensure that all our patients receive the highest quality care possible. Please list any additional comments below.

_____

_____

_____

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Patient Name:_____Date:_____Time:_____

1. How long did it take you to fall asleep after the lights were turned out?

   _____hr_____min.

2. How does this compare with the length of time it usually takes you to fall asleep? (*Circle One*) **much longer than usual** **longer than usual** **same as usual** **shorter than usual** **much shorter than usual**

3. How long do you feel you slept?_____hr_____min

4. How does this compare with the length of time you usually sleep? (*Circle one*)

   much longer than usual **longer than usual** **same as usual** **shorter than usual** **much shorter than usual**

5. How many times do you remember waking?_____times

6. How do you feel right now? (*Circle one*)

   very tired & sleepy **awake but not alert** **rested** **alert & wide awake**

7. Do you have any physical complaints? Yes_____ No _____ If so, describe:

8. Rate the quality of your sleep by circling one number in each of the five categories listed below.
   My sleep last night was:

	Very						Very	
a. Deep	1	2	3	4	5	6	7	Light
b. Short	1	2	3	4	5	6	7	Long
c. Interrupted	1	2	3	4	5	6	7	Uninterrupted
d. Dreamless	1	2	3	4	5	6	7	Many Dreams
e. Restless	1	2	3	4	5	6	7	Restful

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Patient Name:_____Date:_____

9. Do you remember any dreams? Yes_____ No_____ If yes, describe them in detail:

10. What awakened you this morning? (*Circle and describe*)

    Noise

    Discomfort

    Technician

    Spontaneous

    Other

11. In general, how would you say your sleep here in the lab compared with your usual sleep at home? (*Circle one*)

much worse than usual	**worse than usual**	**same as usual**	**better than usual**	**much better than usual**

12. ***If*** you used CPAP/BIPAP, then please answer the following questions:
    Was the CPAP/BIPAP & Mask:
    a. Helpful_____ Somewhat Helpful_____ Not Helpful_____
    b. Comfortable_____ Somewhat Comfortable_____ Uncomfortable_____
    c. Great_____ Okay_____ Unacceptable_____
    d. Proper Fit_____ Adjustment Needed_____ Poor Fit_____

13. CPAP/BIPAP will be something that I will use: Yes_____ No _____

Comments: