SleepSpan

Home Sleep Study: Morning Questionnaire

Question	Yes ☐	No ☐	Comment/Details
1. Did you sleep with the device for the entire night?			
2. Were you able to set up the equipment without problems?			
3. Did you remove or adjust the device or any sensors during the night?			
4. Did the device alarm, stop, or make any unusual noises during the night?			
5. Did you get up during the night (for example, to go to the bathroom)?			
6. Did you take any medications last night (including sleep aids or pain relievers)?			
7. Did you remove the device at any point before getting out of bed in the morning?			
8. Do you feel rested this morning?			
9. Did you experience any discomfort, skin irritation, or pain from the device/sensors?			

Optional: Please note any other comments or issues about your sleep or device use below:

_____

_____

Wake-up time this morning: _____

Approximate time you fell asleep last night: _____