Evening and Morning Questionnaire

Patient Name: ______________________ Date: ________________

Evening

1) Study date

Date: ______________________________________

2) What time did you get to bed?

Time: ______________________________________

3) What time did you turn off the lights?

Time: ______________________________________

Night

1) Did any electrodes fall off during the night?

☐ Yes ☐ No

2) Did you drink any alcohol last evening?

☐ Yes ☐ No

3) Did you take any medications?

☐ Yes ☐ No

If yes, please list all medications:

____

4) How long do you think it took you to fall asleep?

Approximately ___________ minutes

5) What time did you wake up this morning?

Time: ______________________________________

6) How many times did you wake up last night?

Number of times: _________

7) Please tick the box that best describes your sleep last night:

☐ Poor ☐ Good ☐ Very Good

8) Please tick the box that best describes how your sleep last night compared to normal:

☐ Worse ☐ Same ☐ Better