Ambulatory Study Questionnaire

INSTRUCTIONS: Please complete this questionnaire after waking up in the morning.

Name: ___________________________________________ Date of Birth: ______ Date: ______ SDC: ______

Test Performed:   □ ApneaTrak   □ ApneaLink   □ Oximetry   □ ApneaLink Plus

1. Did you have any alcoholic beverages on the day of the test?  □ Yes □ No
   If yes, what time(s) were the beverages consumed? ______________________________________

2. Did you take any medication prior to sleeping or during the night?  □ Yes □ No
   If yes, please list medication(s) ______________________________________________________

3. What time did you turn out the lights and attempt to go to sleep last night? ___________________________

4. How long did it take you to fall asleep last night? (please estimate) __________________________ minutes

5. Did you have any difficulty sleeping?  □ Yes □ No
   If yes, please explain. ..............................................................................................................................

6. What time did you get out of bed this morning? __________

7. How long did you sleep? (please estimate) _______ hours _______ minutes

8. How deeply do you feel you slept last night? (please rate)
   □ Very Deep      □ Deep       □ Average       □ Light       □ Very Light

9. How did you sleep last night compared to a typical night for you? __________________________________________________________

10. Where there any unusual circumstances that disturbed your rest or sleep? □ Yes □ No
    If yes, please explain. ..............................................................................................................................

11. Did you use any of the treatment(s) below last night? (Check all that apply. This does not include testing equipment)
    □ CPAP      □ BiPAP   □ ASV   □ Oral appliance (for treatment of sleep apnea) □ Provent  □ O2 □ No treatment used

12. Did you use the treatment(s) all night?  □ Yes □ No
    If no:  What time did you stop the treatment(s)? __________________________
     Did you also remove the testing equipment? □ Yes □ No

    Did you have any difficulty with the treatment? □ Yes □ No
    Please specify: .................................................................................................................................

13. Was there any witness to your sleep last night? □ Yes □ No, I slept alone
    □ My bed partner slept well and made no comments   □ I snored
    □ My breathing sounded normal with no snoring    □ I had gasping/choking

14. In what position(s) did you sleep last night? (check all that apply) □ Back □ Sides □ Stomach
    Other Comments: ......................................................................................................................................