

**POLYSOMNOGRAPHY NOX T3****Questions regarding the night with examination equipment and your general sleep difficulties:**

When do you think you fell asleep last night? \_\_\_\_\_ How many times were you awake during the night? \_\_\_\_\_

When and for how long were you awake? \_\_\_\_\_

What time did you get up in the morning? \_\_\_\_\_ How many hours did you sleep in total last night? \_\_\_\_\_

How was your night?  **Better than usual**  **As usual**  **Worse than usual**

Do you snore often?  **Yes**  **No**  **Occasionally**  **Not sure**

Does your snoring disturb others in the same room?  **Yes**  **No**  **Occasionally**  **Not sure**

Do you have trouble falling asleep at night?  **Yes**  **No**  **Occasionally**

How many hours do you usually sleep per night? \_\_\_\_\_

Do you have trouble with restless sleep?  **Yes**  **No**  **Occasionally**

Do you wake up during the night?  **No**  **Often**  **Occasionally** Do you know why? \_\_\_\_\_

Are you exhausted in the morning?  **Yes**  **No**  **Occasionally**

Do you wake up with a headache?  **Yes**  **No**  **Occasionally**

Does a dry mouth affect you in the morning?  **Yes**  **No**  **Occasionally**

Are you tired during the day?  **Yes**  **No**  **Occasionally**

Do you need to sleep during a typical day?  **Yes**  **No**  **Occasionally**

Do you fall asleep in inappropriate places or at inconvenient times?  **Yes**  **No**  **Occasionally**

Do your sleep issues affect your daytime functioning?  **Yes**  **No**  **Occasionally**  **Not sure**

Are you or have you been on sick leave due to sleep problems?  **Yes**  **No**

Comments: \_\_\_\_\_